

BAPTIST HOSPITALS OF SOUTHEAST TEXAS

MEDICAL STAFF BYLAWS

AND

RULES AND REGULATIONS

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MEDICAL STAFF BYLAWS
THE BAPTIST HOSPITALS OF SOUTHEAST TEXAS

PREAMBLE

WHEREAS, The Baptist Hospitals of Southeast Texas (Corporation") is a Texas not-for-profit corporation, that owns and operates a hospital d/b/a Baptist Beaumont Hospital located at 3080 College Street in the City of Beaumont, Jefferson County, Texas (the "Hospital");

WHEREAS, the purpose of the Hospital is to serve as a general community hospital providing patient care, education and research;

WHEREAS, the laws, regulations, customs and generally recognized professional standards that govern hospitals as well as the Bylaws of the Corporation require that all practitioners practicing at the Hospital be formally organized into a collegial body of professionals, providing for its member's mutual education, consultation, and clinical support, constituting the Hospital's medical staff;

WHEREAS, a hospital's medical staff is the organization to which a hospital's governing body must delegate responsibilities relating to, and exact accountability for, the quality and appropriateness of professional performance, subject to the ultimate authority of the governing body;

WHEREAS, the Hospital's governing body and its management require a source of collective advice from the professionals practicing at the Hospital in aid of policy formulation, enforcement, planning, coordination of services and governance;

WHEREAS, a purpose of the Hospital and the Corporation is to provide quality care to patients, which requires a cooperative effort among the professionals practicing in the Hospital and between them and the Hospital's governing body and management, with well-defined lines of communication, responsibility, and authority;

WHEREAS, it is recognized that the Medical Staff has the overall responsibility for the quality of medical care provided in the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Hospital's governing body of the Corporation; and that the cooperation of the Medical Staff, the Chief Executive Officer of the Corporation, and the Hospital's governing body are necessary in order to fulfill the Hospital role and purpose to its patients as a general community hospital; and

WHEREAS, the Hospital's governing body is the Board of Directors of the Corporation.

NOW, THEREFORE, the Physicians, Dentists, Podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff, in conformity with these Bylaws, rules and regulations, and the articles of incorporation, bylaws, policies, and rules and regulations of the Corporation;

DEFINITIONS

In these Bylaws, and in the Rules and Regulations adopted in connection herewith, unless the context clearly otherwise requires, the following definitions shall apply:

1. **ALLIED HEALTH PROFESSIONAL or AHP** means an individual, other than a Physician, Dentist, or Podiatrist, not in a recognized training program within or affiliated with the Hospital, who may or may not exercise independent judgment within the scope of his/her lawful professional practice and who is legally qualified to render direct or indirect medical, surgical, dental, podiatric, or health care under the supervision of a Staff member who has been accorded Privileges to provide such care in the Hospital. Allied Health Professionals shall be divided into two categories: (rev. 12/2024)
 - (a) Privileged Allied Health Professionals (Advanced Practice Professionals) shall consist of Physician Assistants, Advanced Practice Registered Nurses (i.e. nurse practitioners, clinical nurse specialists and CRNA), Certified Anesthesiologist Assistants, Psychologists and Clinical Pharmacists. (rev. 12/24)
 - (b) Non-Privileged Health Professionals shall consist of Registered Nurses, Licensed Vocational Nurses, Medical Assistants, Certified Podiatric Assistants, Dental Assistants, Surgical Assistants, Surgical Technicians, Ophthalmic Assistants, Audiologists, Prosthetists, Orthotists, Histotechns and neurological monitoring technicians.
2. **BOARD OF TRUSTEES or BOARD** means the governing body of the Hospital.
3. **BYLAWS** means the entire body of provisions as set forth herein concerning the organization and methods of operation of the Medical Staff, as approved by the Board.
4. **CHIEF EXECUTIVE OFFICER** means the Administrator of the Hospital appointed by the Board to act on its behalf in the overall administration and management of the Hospital.
5. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a Physician, Dentist, Podiatrist or Advanced Practice Professional in accordance with these Bylaws to render specific diagnostic, therapeutic, medical, surgical, dental, or podiatric services to patients in the Hospital.
6. **DENTIST** means an individual with a D.D.S. or other appropriate degree who is fully licensed to practice dentistry in the State of Texas.

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7. **EX-OFFICIO** means service as a member of a body by virtue of an office or position held and does not includes voting rights. (unless specifically otherwise provided)
8. **HOSPITAL** means the hospital facility operated by the Corporation at 3080 College Street in the City of Beaumont, Jefferson County, Texas.
9. **MEDICAL EXECUTIVE COMMITTEE or MEC** means the Medical Executive Committee of the Medical Staff as created by these Bylaws.
10. **MEDICAL STAFF or STAFF** means the formally organized body of all Physicians, Dentists, and Podiatrists who are privileged in accordance with these Bylaws to be a member of the Medical Staff of Baptist Hospital of Southeast Texas, and to attend patients in the Hospital.
11. **MEDICAL STAFF YEAR** means each calendar year beginning each January 1 and ending on the following December 31.
12. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is fully licensed to practice medicine in the State of Texas.
13. **PODIATRIST** means an individual with a D.P.M. of other appropriate degree who is fully licensed to practice podiatric medicine in the State of Texas.
14. **PRACTITIONER** means, unless otherwise expressly limited, a licensed physician, dentist, or podiatrist who has applied for Staff appointment or who has been appointed to the Medical Staff and is authorized to provide services in the Hospital. The term "Practitioner" shall not include Allied Health Professionals, house staff, or medical students.
15. **MEDICO-ADMINISTRATIVE OFFICER** means a Staff member, under contract with the Hospital on a full or part-time basis, whose contractual duties at the Hospital include certain responsibilities which are both administrative and clinical in nature.
16. **PROFESSIONAL REVIEW BODY** means the Corporation and the Board or any committee of the Corporation or any committee of the Medical Staff which conducts review of proposed corrective actions, and includes any committee of the Medical Staff or the Hospital when assisting the Board in a review of any proposed corrective action.
17. **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested, hand-delivered with return receipt. Notice will be sent to the office address provided by the Staff Member. A Staff Member will be deemed to have been served if the Special Notice has been sent by certified mail two (2) times and the Staff Member has not retrieved the Notice.
18. **SPECIFIED SERVICES** means such medical, surgical, dental, podiatric, or health care services which an AHP has been authorized to provide in accordance with these Bylaws to patients of the Hospital.
19. **ADVERSE RECOMMENDATION OR ACTIONS** means a recommendation or action as defined in Article VIII of these Bylaws.

ARTICLE I
NAME

The name of this organization shall be the "Medical Staff of Baptist Hospitals of Southeast Texas."

ARTICLE II
PURPOSE AND RESPONSIBILITIES

2.1 PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff shall be as follows:

- (a) To provide the formal organizational structure by which Practitioners may be reviewed and approved to treat and attend to the medical, surgical, dental, and podiatric needs of the patients of the Hospital and provide Specified Services in the case of Allied Healthcare Professionals;
- (b) To Serve as the primary means through which the Board may, through defined Medical Staff components, monitor and review, on a periodic basis, the appropriateness of the professional performance and ethical conduct of each individual Practitioner holding membership on the Medical Staff;
- (c) To strive toward the upgrading of patient care provided at the Hospital consistent with generally recognized and accepted standards and local resources available;
- (d) To develop an organizational structure, reflected in the Medical Staff bylaws, rules, regulations, and other related protocols and manuals, which adequately define accountability of the Medical Staff and its various committees, and is designed to assure that each member of the Medical Staff exercises responsibility and authority commensurate with his/her contributions to patient care at the Hospital and fulfills like accountability obligations;
- (e) To provide a means through which the Medical Staff may provide input to the Board and the Chief Executive Officer with respect to the Hospital's policy-making and planning processes; and

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- (f) To promote education and research and to participate in the promotion of the general health of the community which the Hospital serves.

2.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff shall be as follows:

- (a) To implement and conduct the following specific activities in order to supervise the quality and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital:
- (1) review and evaluation of the quality of patient care through an appropriate patient care quality assessment plan;
 - (2) on-going monitoring of selected patient care practices through defined mechanisms and Staff organization components;
 - (3) credentials evaluation of Practitioners practicing or seeking the privilege to practice in the Hospital and for defining privileges for Practitioners and Specified Services for Allied Health Professionals;
 - (4) continuing education programs, and
 - (5) utilization review in order to allocate inpatient medical and health services based upon patient-specific determinations of individual medical needs;
- (b) To make recommendations to the Board regarding Staff and AHP appointments, Staff category and section assignments, AHP section assignments, Clinical Privileges and Specified Services for Allied Health Professionals;
- (c) To make recommendations to the Board regarding programs for the establishment, maintenance, continuing improvement and enforcement of generally recognized and accepted professional standards in the delivery of health care within the hospital;
- (d) To account to the Board for the quality and efficiency of patient care at the Hospital through regular reports and recommendations concerning the implementation, operation and results of the Staff's quality review, evaluation and monitoring activities;
- (e) To initiate and pursue corrective action with respect to Practitioners and Allied Health Professionals, when warranted, and to make recommendations to the Board regarding corrective action and to provide a fair hearing plan to hear any appeal from any adverse action by the Board and/or the Staff with respect to any Practitioner or Allied Health Professional;
- (f) To develop, administer, make recommendations regarding amendments to these Bylaws and the Rules and Regulations of the Staff;
- (g) To seek compliance with these Bylaws, the Rules and Regulations of the Staff and other Hospital policies by Practitioners and Allied Health Professionals at the Hospital;
- (h) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs; and
- (i) To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.
- (j) To represent and participate in any hospital deliberation affecting the discharge of medical staff responsibilities.

ARTICLE III
MEDICAL STAFF MEMBERSHIP
AND APPOINTMENT PROCEDURES

3.1 QUALIFICATIONS OF MEDICAL STAFF MEMBERSHIP

Each practitioner seeking or enjoying appointment to membership on the Medical Staff must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board basic qualifications as a prerequisite for staff membership.

A. Basic Qualifications:

- (1) Hold a currently valid license issued by the State of Texas to practice medicine, dentistry, or podiatry and must be able to document his/her background, education, training, experience and demonstrated competence in his/her area of practice appropriate for the Staff category and Clinical Privileges to which he/she seeks or holds appointment;
- (2) Must be able to document his/her health status, his/her adherence to the ethics of his/her profession, his/her good reputation, his/her ability to work with others on a professional basis, and his/her compliance with other qualification requirements specified elsewhere in these Bylaws; and
- (3) Must agree at all times to abide by these Bylaws and the Rules and Regulations of the Medical Staff

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- (4) A willingness and capability, based on current attitude and evidence of performance to work with and relate to other Staff members, members of other health disciplines, and Corporation management and employees, in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality patient care and to participate equitably in the discharge of Staff obligations appropriate to Medical Staff membership in the category sought or held
 - (5) To be free of or have under control any physical or behavioral impairment that if not controlled interferes with or presents a substantial probability of interfering with any of the qualifications set out herein such that patient care is or is likely to be adversely affected; and
 - (6) Professional liability insurance is not less than the minimum amount as determined by the Board after consultation with the Medical Executive Committee
 - (7) Must not be excluded from or prohibited from participating by government action in the Medicare program, State health care programs (Medicaid) or other governmental health care programs
 - (8) Must be willing to provide all information requested upon application for appointment or reappointment to the Medical Staff, including at least:
 - (a) previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;
 - (b) voluntary or involuntary termination of medical staff membership or voluntary limitation, reduction or loss of clinical privileges at another hospital;
 - (c) involvement in any professional liability action (including past or currently pending any malpractice claims, suits, or settlements, or arbitration proceedings
 - (9) Have actively practiced in the specialty for which he/she is requesting privileges at least eighteen months out of the last twenty-four months (residency or private practice). Exceptions may be granted in special circumstances
 - (10) Have actively practiced in the specialty for which he/she is requesting privileges in an accredited hospital at least two of the past five years. Exceptions may be granted in special circumstances.
 - (11) Have established or plan to establish an office and residence within a reasonable distance from the Hospital to allow continuous care of your inpatients. If joining a group, at least one-half of the group must live within a reasonable distance.
- B. On or after December 9, 2019, every new applicant must also satisfy at least one of the following qualifications at the time of appointment:
- (1) Be currently or previously Board Certified in the specialty and subspecialty for which privileges are requested;
 - (2) Successfully completed residency and/or fellowship training in a program in the specialty and subspecialty for which privileges are requested, such program being approved by the appropriate association from among the American Board of Medical Specialties, the American Dental Association, the American Osteopathic Association, or the American Podiatric Association, and obtain certification in the specialty and/or subspecialty for which privileges are requested within the initial period of board eligibility as prescribed by the relevant (sub) specialty board.

Failure to become Board Certified within the time period stated shall result in automatic termination from the Medical Staff. Clinicians who are terminated for failure to obtain board certification within the time periods stated shall not be eligible to reapply to the Medical and Dental Staff until they have attained board certification in the specialty and subspecialty area for the clinical privileges requested.

"Board Certification" as used herein shall mean that the relevant clinician has been fully and unconditionally certified in the specialty in which he/she conducts the majority of his/her practice (and sub-specialty, if the majority of the practice is conducted in a sub-specialty) by the appropriate board from among the American Board of Medical Specialties, American Dental Association, American Osteopathic Association, or the American Podiatric Association, as the case may be. Refer to Credentials Manual regarding exceptions to board certification requirements that may be granted in special circumstances.

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3.2 NATURE OF MEDICAL STAFF MEMBERSHIP

- (a) Membership on the Medical Staff or the exercise of Clinical Privileges by Members (including temporary Privileges) is a privilege which shall be extended only to those professionally competent Physicians, Dentists, and Podiatrists who meet the qualifications, standards and requirements set forth in the Credentials Policy and Procedure Manual, including, but not limited to, requirements regarding education, training, residency, licensure, insurance, and Board Certification.
- (b) Appointment to and membership on the Medical Staff shall confer on the appointee or member only such Clinical Privileges as have been specifically granted by the Board in accordance with these Bylaws.
- (c) No Physician, Dentist, Podiatrist shall admit or attend to patients in the Hospital unless he/she is a member of the Medical Staff with Privileges, or has been granted temporary Privileges in accordance with the procedures set forth in these Bylaws.
- (d) Physicians on staff (except Contracted Physicians – see (e) below) are independent contractors and not employees, agents, or servants of the hospital. While the physicians on staff are required to follow the rules and policies of the hospital, the hospital does not and cannot control the details of the physician's work.
- (e) A Physician providing direct patient care services in the Hospital pursuant to a contract with the Hospital must be a member of the Medical Staff, meet the same basic qualifications for appointment to the Medical Staff, be evaluated for appointment, reappointment and clinical privileges in the same manner, and fulfill all the obligations of his/her Medical Staff category. In the performance of the contracted professional's medical services, Physician shall exercise his or her professional judgment.

3.3 EFFECT OF OTHER AFFILIATIONS

No Physician, Dentist, or Podiatrist shall be automatically entitled to Medical Staff membership or to the exercise of particular Clinical Privileges merely because he/she is licensed to practice medicine, dentistry, or podiatry in this or any other state, or because he/she is certified by any clinical board, or because he/she has previously had Staff membership or Privileges at this Hospital or has had, or presently has, staff membership or privileges at another health care facility.

3.4 NONDISCRIMINATION

Eligibility for Medical Staff membership or particular Clinical Privileges shall not be determined or denied on the basis of sex, race, age, creed, color, handicap or national origin.

3.5 RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

Each member of the Medical Staff, regardless of his/her assigned Staff category, and each Practitioner exercising temporary privileges under these Bylaws shall have the following basic responsibilities and obligations:

- (a) To provide continuous professional care to his/her patients treated at the Hospital at generally recognized and accepted professional levels;
- (b) To continually abide by these Bylaws and the Rules and Regulations of the Medical Staff, as well as all other applicable standards, policies and rules of the Hospital, including the Hospital's Professional Conduct Policy, which requires all members of the health care team to treat each other with respect, dignity, and honesty;
- (c) To discharge appropriately such Staff, section, subsection, committee and Hospital functions for which he/she is responsible by virtue of his/her Staff category, assignment, appointment, election or otherwise;
- (d) To prepare and complete in a timely fashion the medical and other required records for all Hospital patients he/she admits or in any way attends to in the Hospital;
- (e) To strictly abide by the principles of ethics adopted by the American Medical Association, American Osteopathic Association, the American Dental Association, or the American Podiatric Medicine Association as applicable, in his/her activities, practices and conduct;
- (f) To fully cooperate with the Board, the Chief Executive Officer, and the Hospital's administrative staff and employees in the operation of the Hospital; and
- (g) To maintain professional liability insurance in not less than the required minimums required by the Credentials Manual at all times while a member of the Active, Limited and Telemedicine Staff, and any cancellation, non-renewal, or material modification must be reported to the Chief Executive Officer for action in accordance with the Credentials Manual.
- (h) To fulfill on-call responsibilities as specified in the Bylaws, Rules and Regulations and Policies and Procedures of the Hospital and Medical Staff.

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- (i) A complete history and physical examination (H&P) for each admission and surgical procedure is to be completed within 24 hours after the patient's admission/registration or prior to a surgical procedure, or a procedure requiring anesthesia. The medical history and physical examination should be completed and documented by a practitioner who has been granted privileges to do so. If the H&P is not done at the time of admission, the H&P can be performed a maximum of 30 days prior to the patient's admission or procedure, by another qualified licensed individual in accordance with state law, however, an updated note reflecting the presence or absence of changes in the patient's condition must be completed by an individual granted H&P privileges, within 24 hours following the patient's admission or registration. In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services. (rev. 12/15/14) (rev. 8/22/22)

3.6 CONDITIONS OF APPOINTMENT

- (a) Initial appointments and reappointments to the Medical Staff, and all modifications thereto, shall be made by the Board upon recommendation from the MEC in accordance with these Bylaws as more fully described in the Credentials Manual.
- (b) Initial appointments as an Active, Limited or Telemedicine Member of the Staff shall be on a provisional basis for a twelve month observation period. An appointee shall remain subject to observation until he/she has met the qualifications and standards required by each Section as provided for in the Credentials Policy and Procedure Manual.
- (c) Reappointments to any category of the Medical Staff shall be for a period of not more than two years.
- (d) Any member of the Medical Staff who has not performed any type of patient care activity during the previous period of review will be deemed to have voluntarily resigned his/her clinical privileges.

3.7 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

(a) General Procedures

The Medical Staff through its designated sections, committees and officers, as specified by these Bylaws and the Credentials Manual, shall evaluate and consider each application for appointment or reappointment to the Staff, as well as each request for modification of Staff status or Privileges, and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform the same evaluation, and recommendation functions with respect to any AHP who requests authority to provide Specified Services in the Hospital. The mechanisms for making and evaluating Medical Staff and for applying for and maintaining AHP status are set out in the applicable Credentials Manual.

(b) Application for Initial Appointment

Each applicant seeking initial Staff appointment or AHP status shall complete and submit an application on the form and in the manner specified in the Hospital's applicable Credentials Policy and Procedure Manual. The appointment process specified in these Bylaws and the Hospital's Credentials Policy and Procedure Manual shall be adequately described to each applicant.

- (c) In considering applications for Medical Staff membership and privileges or the renewal, modification, or revocation of medical staff membership and privileges, the Medical Staff through its designated sections, committees and officers as specified by these Bylaws and the Credentials Policy and Procedure Manual, shall afford each Practitioner procedural due process. The Credentials Policy and Procedure Manual will reflect compliance with current local, state, and federal laws.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall consist of Active, Membership-No Privileges, Limited, Honorary and Telemedicine categories. All appointments and reappointments to the Medical Staff shall designate the category in which such appointment or reappointment has been made.

4.2 ACTIVE STAFF

(a) Qualifications

The Active Staff shall consist of Physicians, Dentists, and Podiatrists each of whom shall:

- (1) meet the basic qualifications set forth in Hospital's Credentials Policy and Procedure Manual;
- (2) be located closely enough to the Hospital (as specified in the Hospital's Credentials Policy and Procedure Manual) to provide continuous care to their patients; and
- (3) regularly admit patients to, or be otherwise regularly involved in the care of patients in the Hospital.

(b) Prerogatives

The prerogatives of an Active Staff member shall be to:

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- (1) admit patients without limitation, unless otherwise provided in the Medical Staff Rules and Regulations;
- (2) exercise such Clinical Privileges as are granted to him/her pursuant to these Bylaws;
- (3) vote on all matters presented at general and special meetings of the Medical Staff and at section, subsection, and committee meetings of the Staff of which he/she is a member, unless otherwise provided by resolution of the Staff or a section or committee of the Staff, which has been approved by the Medical Executive Committee and the Board; and
- (4) hold elective or appointive office in the Staff organization, in the applicable Staff sections and subsections, and in committees of the Medical Staff, unless otherwise provided by resolution of the Staff or a section or committee of the Staff which has been approved by the Medical Executive Committee and the Board.

(c) Responsibilities

The responsibilities of an Active Staff member shall be to:

- (1) meet the basic responsibilities set forth in Section 3.5;
- (2) retain responsibility within the area of his/her professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, and arrange a suitable alternative for such care and supervision;
- (3) actively participate in the patient care AUDIT, utilization review and other quality evaluation and monitoring activities required of the Staff, in supervising initial appointees to which he/she may be assigned, in the emergency services program of the Hospital, and in discharging such other Staff functions as may be required of him/her from time to time; and
- (4) satisfy the requirements set forth in these Bylaws for attendance at meetings of the staff and of the sections and committees of which he/she is a member.

Failure to fulfill these responsibilities may be grounds for corrective action or denial of reappointment. In such event, the member shall be afforded all procedural rights provided in Article VIII of these Bylaws.

4.3 MEMBERSHIP- NO PRIVILEGES

(a) Qualifications

This category of Membership – no privileges Staff shall consist of Physicians, Dentists, and Podiatrists each of whom shall:

- (1) meet the basic qualifications set forth in Hospitals Credentials Policy and Procedure Manual,
- (2) be initially credentialed in the same manner as an Active Staff member with reappraisal consisting of verification of current licensure/insurance, NPDB query, and verification of no government sanctions.

(b) Prerogatives

The prerogatives of Membership- no privileges Staff - shall be:

- (1) regularly direct patients to the hospital through referrals to other members of the medical staff who have appropriate privileges for evaluation/admission
- (2) no clinical privileges associated with this category, although Staff members will be assigned to a primary Section affiliation
- (3) may visit those hospitalized patients, discuss patient care with the attending physician and review the medical record (with awareness of attending physician)
- (4) cannot write orders or make medical record entries for in-house patients (admission orders must be written by the admitting physician)
- (5) may order tests and procedures on an outpatient basis
- (4) not eligible to vote on matters presented at general and special meetings of the Medical Staff and at section, subsection, and committee meetings of the Staff of which he/she is a member, unless otherwise provided by resolution of the Staff or a section or committee of the Staff, which has been approved by the Medical Executive Committee and the Board.

(c) Responsibilities

The responsibilities of Membership – no privileges Staff member shall be to:

- (1) meet the basic responsibilities set forth in Section 3.5 (b), (c), (f) and (g)
- (2) designate who their admitting physician is
- (3) shall be required to pay application fee
- (4) shall be required to complete a modified reappointment application

The granting of appointment to Membership – No Privileges Staff is at the discretion of the Board on the recommendation of the Medical Executive Committee. Refusal to appoint to this category does not entitle the clinician to a hearing or appeal as set forth in these Bylaws and Fair Hearing Plan. Appointment to the Membership – No privileges Staff may be terminated by the Board upon recommendation of the Executive Committee within sixty (60) days written notice to the Staff member, without rights to a hearing or appeal as set forth in these Bylaws and Fair Hearing Plan.

4.4 LIMITED

The Limited Staff shall consist of Physicians, Dentists, and Podiatrists each of whom shall:

(a) Qualifications

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- (1) meet the basic qualifications set forth in the Hospital's Credentials Policy and Procedure Manual; and
- (2) limit their practice to a particular outpatient procedure/examination/clinic, i.e., Diabetes Clinic, Pediatric Clinic, that is not readily available by current members of the Medical Staff;
- (3) not admit patients.

(b) Prerogatives

The prerogatives of a Limited Staff member shall be to:

- (1) treat/examine an unlimited number of outpatients;
- (2) exercise such Clinical Privileges as are granted to him/her pursuant to these Bylaws; and
- (3) attend meetings of the Staff and the section and subsections of which he/she is a member but may not vote, and any Staff or Hospital education programs; but
- (4) not be eligible to vote, or to hold Medical Staff office; and
- (5) not be required to pay annual dues but must pay application fee.

(c) Responsibilities

Each member of the Limited Staff shall be required to discharge the basic responsibilities specified in Section 3.5 except, that no emergency room call duty shall be required and shall be required to make arrangements with an Active Staff member with appropriate Clinical Privileges in the area of medical practice of which the Limited Staff member's specialty is a subspecialty to admit any patient he/she treats on an outpatient basis if the need arises.

4.5 HONORARY STAFF

(a) Qualifications

The Honorary Staff shall consist of Physicians, Dentists, and Podiatrists recognized for other outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, who do not actively practice at the Hospital and who have retired from active practice. The Honorary Staff shall not be reappointed to the Medical Staff.

(b) Prerogatives

Honorary Staff members shall not be eligible to admit patients to the Hospital and/or to exercise Clinical Privileges in the Hospital. They may attend Staff, section and subsection meetings and any Staff or Hospital education meetings. Honorary Staff members shall not be eligible to vote or to hold any office or position in this Medical Staff organization.

(c) Responsibilities

Each member of the Honorary Staff shall have no assigned duties, but shall be required to discharge the basic responsibilities specified in Section 3.5 of these Bylaws.

4.6 TELEMEDICINE STAFF

(a) Qualifications

The Telemedicine Staff shall consist of Physicians, each of whom shall:

- (1) meet the basic qualifications set forth in the Hospital's Credentials Policy and Procedure Manual.

(b) Prerogatives

The Telemedicine Staff member may:

- (1) consult on, render clinical opinions and make recommendations to the attending physician on outpatients and inpatients
- (2) attend meetings of the Staff and the sections/subsections and Medical Staff Committees of which he/she is a member and any Staff or Hospital education programs;
- (3) exercise such Clinical Privileges as are granted to him/her pursuant to these Bylaws.
- (4) not admit patients or be solely responsible for a patient's care;
- (5) not be the primary physician performing any procedure;
- (6) not be eligible to vote at any Staff, section/subsection or Committee meetings, or hold medical Staff office;
- (7) write orders on inpatients and outpatients as delineated in their privileges; and
- (8) not cover calls for an active staff physician.

(c) Responsibilities

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- (1) Each member of the Telemedicine Staff shall be held to the same basic responsibilities specified in Section 3.5 (b) through (g).
- (2) At the conclusion of the provisional period, and at each reappointment time, the Telemedicine Staff member shall provide evidence of clinical performance in such form as may be required by the section chairman or the Credentials Committee in order to allow an appropriate judgment to be made with respect to his/her ability to exercise the clinical privileges requested.

4.7 ASSOCIATE STAFF

(a) Qualifications

The Associate Staff shall consist of medical or osteopathic physicians who have completed at least two years of residency.

(b) Prerogatives

The prerogatives of an Associate Staff member shall be to:

- (1) conduct patient evaluations per their area of specialty, admit patients, and provide medical management for patients in coordination with the attending physician.
- (2) may not be considered members of the Medical Staff
- (3) may not serve as the attending physician.
- (3) may attend meetings but may not vote
- (4) not be required to pay annual dues but must pay initial appointment application fee

4.8 WAIVER OF QUALIFICATIONS

Any qualification or requirement regarding appointment or reappointment to a particular category of the Staff may be waived at the discretion of the Board after consultation with the Medical Executive Committee upon determination that such waiver will serve the best interest of patient care in the Hospital.

4.9 MEDICO-ADMINISTRATIVE STAFF

- (a) A Physician, Dentist, or Podiatrist under contract with the Hospital in a purely administrative capacity with no Clinical Privileges or duties shall be subject to the regular personnel policies of the Hospital and to the terms of his/her contract, and need not be a member of the Medical Staff.
- (b) A Medico-Administrative Officer must be a member of the Medical Staff, achieving this status by the procedures provided in these Bylaws for appointment and reappointment. His/her Clinical Privileges must also be determined and delineated in accordance with these Bylaws.
- (c) When the Board desires to contract with a Physician, Dentist, or Podiatrist to fill a position as a Medico-Administrative Officer, the MEC will be consulted for its advice and recommendation.
- (d) A medico-Administrative Officer's Staff membership and Clinical Privileges shall not be contingent on his/her continued status in a Medico-Administrative position, unless otherwise so provided in his/her contractual arrangement with the Hospital.
- (e) All issues which arise with regard to the administrative performance of a Medico-Administrative Officer shall be resolved in accordance with the terms of his/her contractual arrangement with the Hospital.
- (f) All issues which arise with regard to the professional competence, performance, or professional services at the Hospital, Clinical Privileges, health status or any other reason which might require corrective action against the Medico-Administrative Officer shall be governed by the provisions of these Bylaws.
- (g) Whenever the Board determines that it is in the best interest of the administrative efficiency and good patient care practice that a section or subsection be directed by a Medico-Administrative Officer, the Board shall have the right to contract with any such Medico-Administrative Officer after consultation and advice from the MEC as provided in Section 4.9(c) above and provided that such proposed Medico-Administrative Officer is already a Staff Member or is admitted to the Medical Staff prior to his/her appointment by the Board.
- (h) The term of office of any Medico-Administrative Officer shall be determined by his/her contract with the Hospital, and he/she shall not be subject to appointment or reappointment by the President/Chief of Staff.

4.10 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be eligible for Medical Staff membership nor shall these professionals be assigned to a specific Staff category. Allied Health Professionals shall be divided into two categories: Privileged Allied Health Professionals (Advanced Practice Professionals) and Non-Privileged Health Professionals. Both categories shall act as an adjunct to the Medical Staff in accordance with these Bylaws and should comply with the responsibilities of membership as they are applicable to the AHP/APP. The qualifications and procedures for obtaining AHP affiliation and authorization to provide services/clinical privileges in the Hospital are outlined in the Allied Health Professional's Credentials Policy and Procedure Manual.

ARTICLE V

BAPTIST HOSPITAL OF SOUTHEAST TEXAS, INC.
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CLINICAL SECTIONS

5.1 ORGANIZATION OF SECTIONS

As part of the Medical Staff organization structure, clinical sections shall be organized as a division of the Staff and shall have a committee and chairman who is selected and has the authority, duties and responsibilities as specified in these Bylaws. Such sections may be further separated into clinical subsections according to generally accepted specialty practice categories.

5.2 DESIGNATION

(a) Current Sections

The sections of the Medical Staff shall be as follows:

- (1) Medicine/Family Medicine: to include Internal Medicine and other associated sub-specialties of Medicine; and other disciplines of Medicine not elsewhere classified;
- (2) Surgery: to include Neurological Surgery, Proctology, Urology, Thoracic Surgery, Cardiovascular Surgery, Plastic Surgery, Orthopedic Surgery, Ophthalmology, Otolaryngology, Oral Surgery and Dentistry, Pathology, Podiatric Medicine, General Surgery
- (3) Obstetrics/Gynecology
- (4) Anesthesiology; to include Pain Medicine; and
- (6) Pediatric: to include associated subspecialties
- (7) Radiology
- (8) Emergency Medicine

(b) Future Sections

When deemed appropriate and consistent with the provisions of Section 5.5, the Board and the Medical Executive Committee, by their joint action, may create, eliminate, subdivide or combine sections, or any subsections thereof.

5.3 ASSIGNMENTS TO SECTION

(a) Medical Staff

Each member of the Staff shall be assigned to membership in at least one (1) section, but may be granted membership and/or Clinical Privileges in one or more sections, as is deemed appropriate. Each Staff member may also be assigned to a subsection or subsections of any applicable section, if deemed appropriate, based on the nature and specialty of his/her practice at the Hospital.

(b) Allied Health Professionals

Each AHP approved to provide Specified Services at the Hospital shall be assigned as an adjunct to a subsection or section, as is deemed appropriate, for supervision by the section in accordance with these Bylaws.

(c) Exercise of Privileges and Specified Services

The exercise of Clinical Privileges or the performance of Specified Services within any section (or subsection thereof) shall be subject to the rules and regulations of that section and the authority of the section chairman.

5.4 FUNCTIONS OF SECTIONS

The basic functions and responsibilities of each section of the Medical Staff, which shall be carried out and supervised through the Quality Improvement Committee and the Chairmen, shall be as follows:

- (a) To implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the section and any subsections thereof by:
 - (1) review at each semi-annual section meeting the report of the Quality Improvement Officer for such section, including the identification of the indicators used to monitor the quality and appropriateness of patient care in the section, the evaluations of patient care provided by Practitioners with delineated Clinical Privileges in the section, and the finding, conclusions, recommendations, and actions taken by the Physician Quality Improvement Committee and all relevant reports received by the section from the appropriate Medical Staff Committees or Hospital Committees on utilization review, infection control, patient safety programs, and results of Hospital Risk Management activities related to the clinical aspects of care and safety in the section;
 - (2) to draw conclusions, formulate recommendations, and initiate actions based on the review of Quality Improvement information set out in Section 5.4(a) and (1) above and to communicate such conclusions, recommendations, and actions taken to the MEC and to other appropriate Medical Staff Committees, section members, and Medical Staff sections; and
 - (3) establishing rules and regulations for the granting and exercise of Clinical Privileges and the granting and performance of Specified Services within the section and any subsections thereof, which shall be submitted to the MEC and the Board for approval;

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- (b) To conduct and participate in, and make recommendations to the MEC regarding the need for continuing education programs at the Hospital;
- (c) To monitor, on a continuing basis, adherence to the following within the section:
 - (1) Hospital and Staff policies and procedures, including these Bylaws, the Rules and Regulations of the Staff, and the rules and regulations of the section promulgated pursuant hereto;
 - (2) Section and Staff requirements for alternate coverage and consultations; and
 - (3) Hospital fire and other regulations designed to promote patient safety;
- (d) To coordinate patient care provided within the section and any subsections thereof by Staff members and AHPs with Hospital nursing services, ancillary patient care services, and administrative support services;
- (e) To submit written reports to the MEC on a regular basis concerning the following:
 - (1) The findings of the section's (and any subsections thereof) review, evaluation, and monitoring activities, actions taken thereon, and the results of such actions;
 - (2) its recommendations for maintaining and improving the quality of care provided within the section (and any subsections thereof) and the Hospital; and
 - (3) such other matters as may be from time to time requested by the MEC;
- (f) To meet at least semi annually
- (g) To establish such committees or other mechanisms and develop such section rules and regulations (which shall be submitted to the MEC and the Board for approval) as are necessary and appropriate to properly perform the functions and responsibilities assigned to it by these Bylaws, the Staff Rules and Regulations, and other Hospital policies; and
- (h) To elect a chairman-elect as specified in Section 9.8(b).

5.5 MODIFICATIONS TO ORGANIZATION OF SECTIONS

In creating, eliminating, subdividing, or combining sections, any subsections thereof, or any other clinical organization units that may exist or be contemplated, the following guidelines shall be followed:

- (a) Creation or Subdivision
 - (1) a sufficient number of Practitioners are available for assignment to and will be assigned to and actively participate in the new organizational component, so as to enable such new component to accomplish the functions generally assigned to such component by these Bylaws and the Staff Rules and Regulations; and
 - (2) the patient or service activity to be associated with the new component is substantial enough to warrant development of the new component.
- (b) Elimination or Combination
 - (1) the number of available Practitioners is no longer sufficient and will not be so within the foreseeable future to allow accomplishment of assigned functions and responsibilities; or
 - (2) the patient or service activity associated with the component to be eliminated or combined is no longer substantial enough to warrant continued maintenance of the component.

ARTICLE VI
CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

- (a) Privileges are granted upon recommendation of the Section Chairman, Credentials Committee and Medical Executive Committee with approval by the Board of Trustees.
- (b) No Physician, Dentist, Podiatrist or other professional may provide clinical services at the Hospital unless he/she is a Staff member with delineated Clinical Privileges, has been granted temporary Privileges, or is exercising emergency Privileges. Staff members shall be entitled to exercise only those Clinical Privileges specifically granted to them by the Board pursuant to these Bylaws. All clinical Privileges so granted must be within the scope of the Staff member's license and any restrictions placed thereon. The specific requirements and procedures for the granting of initial clinical privileges, changes in clinical privileges, and the granting of temporary or emergency privileges are delineated in the Credentials Policy and Procedure Manual.

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ARTICLE VII
CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

(a) Criteria for Initiation

Whenever the professional practices and activities of a Practitioner with Clinical Privileges or authority to provide Specified Services are considered to be improper or lower than the standards of the Medical Staff, or such Practitioner engages in, makes or exhibits acts, statements, demeanor or professional conduct, either within or outside of the Hospital, and the same is, or is reasonably likely to be, detrimental to patients safety or to the delivery of good patient care, or is reasonably likely to be, disruptive to Hospital operations, corrective action against such Practitioner may be initiated by any officer of the Medical Staff, by the chairman of any section in which such Practitioner is assigned or exercises Clinical Privileges or Specified Services, by the chairman of any standing committee of the Medical Staff, by the Chief Executive Officer, by the Board, by any officer of the Board, or by the chairman of the Corporation's Quality Improvement/Quality Assessment Committee.

(b) Requests and Notices

All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The chairman of the MEC shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the committee and shall continue to keep him/her fully informed of all action taken in conjunction therewith. The chairman of the MEC shall also promptly notify by Special Notice the affected Practitioner that a request for corrective action has been submitted, specifying the nature of the matter which made the basis of the request and shall keep the Practitioner informed of all action taken in conjunction therewith.

(c) Investigation

After deliberation, the MEC may either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The MEC may conduct such investigation itself or may assign this task to an officer, section or committee of the Medical Staff. This investigative process shall not be deemed a "hearing" as that term is used in Article VIII, but may include consultation with the Practitioner involved.

If the investigation is accomplished by a group or individual other than the MEC, such group or individual shall forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and may at the request of the Board (or of the Executive or Professional Relations Committee thereof), terminate the investigative process and proceed with action as provided in Section 7.1(d).

(d) MEC Action

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within thirty (30) days after receipt of the request for corrective action unless deferred pursuant to Section 7.1(e), the MEC shall take action upon such request. Such action may include, without limitation:

- (1) recommending rejection of the request for corrective action;
- (2) recommending a warning; a letter of admonition, or a letter of reprimand;
- (3) recommending terms of probation or individual requirements of consultation;
- (4) recommending reduction, suspension or revocation of Clinical Privileges or Specified Services;
- (5) recommending reduction of Staff category or limitation of any Staff prerogatives directly related to the Practitioner's delivery of patient care; or
- (6) recommending suspension or revocation of Staff membership or AHP status.

(e) Deferral

If additional time is needed to complete the investigative process, the MEC may defer action on the request, but only upon the written consent of the affected Practitioner. A subsequent recommendation for any one or more of the actions provided in Sections 7.1(d) (1) through (6) above must be made within fifteen (15) days of the deferral and no longer than forty-five (45) days from the receipt of request for corrective action by the MEC.

(f) Procedural Rights

Any recommendation by the MEC pursuant to Section 7.1(d) (3), (4), (5), and (6), or any combination of such actions, shall entitle the Practitioner or AHP to the respective procedural rights as provided in Article VIII if the action has a duration greater than fourteen (14) days and is done for a reason of competence or conduct.

(g) Other Action

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- (1) If the MEC's recommended action is to reject the request for corrective action, such recommendation, together with all supporting documentation, shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in the Credentials Manual;
- (2)
 - A. If the MEC's recommended action is a warning, admonition or reprimand, such recommendation together with all supporting documentation, shall be transmitted to the Board. Board action to adopt such MEC recommendation without substantive modification shall conclude the matter and notice of final decision shall be given as provided in the Credentials Manual; or
 - B. If the Board's proposed action will modify substantively the MEC's recommendation, the provisions of the Credentials Manual shall be followed. If the Board's action is adverse to the applicant as defined in Section 8.1, the Chief Executive Officer shall promptly so inform the Practitioner by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article VIII; and
- (3) If, in the Board's determination, the MEC fails to act in timely fashion in processing and recommending action on the request for corrective action, the Board (or an appropriate committee thereof) may, after notifying the MEC, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse as defined in Section 8.1, the Chief Executive Officer shall promptly so inform the Practitioner by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article VIII.

7.2 SUMMARY SUSPENSION OR RESTRICTION

(a) Criteria for Initiation

- (1) Whenever a Practitioner's professional practice or conduct is such that failure to take immediate action may result in an imminent danger to the health of any individual present in the Hospital, either the chairman of the MEC or the Chief Executive Officer (or their respective designated representatives), the Executive Committee of either the Medical Staff or the Board, or the Board (or an appropriate committee thereof) shall have the authority to summarily suspend or restrict the Medical Staff membership status or AHP status, and all or any portion of the Clinical Privileges or authority to provide Specified Services of such Practitioner.
- (2) Such summary action shall become effective immediately upon imposition, and the Chief Executive Officer shall promptly give Special Notice of the suspension to the Practitioner. In the event of any such action, the Practitioner's patients then in the Hospital whose treatment by such Practitioner is terminated by the summary action shall be assigned to another Practitioner by the section chairman of the section affected. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

(b) MEC Action

As soon as is reasonably possible after such summary action, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may modify, continue or terminate the terms of the summary action.

(c) Procedural Rights

The practitioner shall be entitled to the procedural rights in Article VIII if the summary action is an Adverse Recommendation or Action or, if not, if the MEC's action under subsection (b) is an Adverse Recommendation or Action. All further procedures shall be set forth in Article VIII.

If neither the summary action nor the MEC's recommendation under subsection (b) are an Adverse Recommendation or Action, the recommendation of the MEC shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in the Credentials Manual, as applicable. The terms of the MEC's action shall remain in effect pending a final decision by the Board.

7.3 AUTOMATIC SUSPENSION

(a) License

- (1) Revocation Whenever a Practitioner's license, certificate or other legal credential authorizing him/her to practice in this State is revoked, his/her Staff membership or AHP status, and his/her Clinical Privileges or Specified Services shall be immediately and automatically revoked;
- (2) Restriction Whenever a Practitioner's license, certificate or other legal credential is limited or restricted by the applicable licensing or certifying authority, those Clinical Privileges or Specified Services which he/she has been granted that are within the scope of said limitation or restriction shall be immediately and automatically revoked;
- (3) Suspension Whenever a Practitioner's license, certificate or other legal credential is suspended, his/her Staff membership or AHP status, and his/her Clinical Privileges or Specified Services shall be automatically suspended effective upon and for at least the term of the suspension, and further action on the matter shall proceed pursuant to Section 7.2; or
- (4) Probation Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her Clinical Privileges and other prerogatives and responsibilities, if any, shall be automatically suspended in the same manner and to the same extent that the terms of the Practitioner's probation limits the exercise of the privileges granted to the Practitioner by the authority issuing the applicable license or certificate and his/her office holding and voting prerogative are suspended for the term of such probation and further action on the matter shall proceed pursuant to Section 7.3(c).

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(b) Drug Enforcement Administration

- (1) Revocation Whenever a Practitioner's Drug Enforcement Administration ("DEA") registration number is revoked, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the number and further action on the matter shall proceed pursuant to Section 7.3(c);
- (2) Suspension Whenever a Practitioner's DEA number is suspended, he/she shall be divested of his/her right to prescribe medications covered by the number effective upon and for at least the term of the suspension, and further action on the matter shall proceed pursuant to Section 7.3(c); or
- (3) Probation Whenever a Practitioner is placed on probation insofar as the use of his DEA number is concerned, his/her right to prescribe medications covered by the number shall be automatically suspended at least for the term of such probation or probations, as the case may be, and further action on the matter shall proceed pursuant to Section 7.3(c).

(c) MEC Deliberation

As soon as reasonably practicable after action is taken as described in Section 7.3(a) (3) or (4) or in Sections 7.3(b) (1), (2), or (3), the MEC shall convene to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation, including limitation of prerogatives. Thereafter the procedure to be followed shall be as provided in Sections 7.1(f) and 7.1(g), as applicable.

(d) Medical Records

For failure to complete medical records in a timely fashion as specified in the Staff Rules and Regulations, a Practitioner's Clinical Privileges (except with respect his/her patients already in the Hospital) and his/her rights to admit patients and to consult with respect to patients shall, after written warning of delinquency, be automatically suspended and shall remain suspended until such medical records are completed and further action on the matter shall proceed pursuant to Section 7.3(c).

(e) Professional Liability Insurance

A Practitioner's Medical Staff Membership shall be automatically suspended for failure to maintain the minimum amount of professional liability insurance required by the Credentials Manual. The procedures for further action and for reinstatement are set out in the Credentials Manual.

- (f) Medicare and Medicaid Participation. Termination, exclusion, or preclusion by government action from participation in the Medicare or Medicaid programs may subject the member's medical staff status and clinical privileges to suspension by the Medical Executive Committee. In the event the individual's participation is not fully reinstated by the expiration of the current appointment term, the individual will be deemed to have resigned from the medical staff at that time.

- (g) Criminal Activity. Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or medical or health insurance fraud or abuse, or violence, or a plea of guilty or nolo contendere to charges pertaining to the same shall result in automatic relinquishment of medical staff appointment and all clinical privileges.

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7.4 PRECAUTIONARY ACTION

- (a) A precautionary suspension or restriction of any or all of a Practitioner's Clinical Privileges for a period not to exceed fourteen (14) days may be imposed by the Medical Executive Committee, the Chief of Staff on behalf of the Medical Executive Committee, or the Chief Executive Officer on behalf of the Board during which a review is conducted to determine the need for further action, including initiation of an investigation under Section 7.1. *[Health Care Quality Improvement Act, 42 USC§11112(c)(1)(B)]*
- (b) The Chief Executive Officer will provide the Practitioner with Special Notice of the precautionary action within one (1) business day or seventy-two (72) hours of its imposition, whichever is shorter, to include a statement of the reason for the action. The Medical Executive Committee will review the basis for the precautionary action within fourteen (14) days of its imposition and may terminate it at any time unless otherwise provided by the Board or its Chair.
- (c) The precautionary action shall automatically terminate after fourteen (14) days and may not be renewed. A precautionary action is not considered corrective or disciplinary action, nor an Adverse Recommendation or Action. It does not entitle the Practitioner to any procedural rights of review under these Bylaws, the Fair Hearing Plan or otherwise.

ARTICLE VIII
PROCEDURAL RIGHTS OF REVIEW

8.1 ADVERSE RECOMMENDATION OR ACTIONS DEFINED

(a) Types of Actions or Recommendations

Unless otherwise provided below, the following recommendations or actions when taken as provided in Section 8.1 (b) below entitle the Practitioner affected thereby to the procedural right or review set out in this Article and as further detailed in the Fair Hearing Plan:

- (1) denial of initial staff appointment;
- (2) denial of reappointment;
- (3) suspension of Staff membership (only if longer than 14 days and is done for reason of competence or conduct);
- (4) revocation of Staff membership;
- (5) denial of requested advancement in Staff Category unless due to failure to document compliance with objective minimum or threshold criteria for advancement;
- (6) reduction in Staff category unless due to failure to document compliance with objective minimum or threshold criteria for the prior Staff category
- (7) limitation of the right to admit patients or of any other staff membership prerogative directly related to the Practitioner's provision of patient care;
- (8) denial of requested Clinical Privileges or Specified Services;
- (9) reduction in or restrictions on Clinical Privileges or Specified Services; (only if longer than 14 days and is done for reason of competence or conduct)
- (10) suspension of Clinical Privileges or Specified Services (only if longer than 14 days and is done for reason of competence or conduct);
- (11) revocation of Clinical Privileges or Specified Services;
- (12) terms of probation; that restrict the exercise of Clinical Privileges;
- (13) individual imposition or mandatory application of consultation requirement that requires the presence of an observer before the Practitioner may exercise a clinical privilege;
- (14) individual imposition of an observation requirement that requires the presence of an observer before the Practitioner may exercise the clinical privilege; and
- (15) any other action that will require a mandatory report to the National Practitioner Data Bank by the Hospital, but not including a surrender or restriction of Clinical Privileges while under an investigation for professional competence or conduct or in return for not conducting such an investigation or taking a professional review action.

(b) Actions or Recommendations Deemed Adverse

A recommendation or action listed in subsection 8.1 (a) above shall be deemed adverse only when it has been:

- (1) recommended by the MEC;
- (2) taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or
- (3) taken by the Board on its own initiative without benefit of a prior recommendation by the MEC.

(c) None of the following actions or recommendations whether taken by the MEC or the Board, or any others specifically so provided in the Bylaws are considered an Adverse Recommendation or Action

- (1) Failure to process an application for initial staff appointment, reappointment, or Clinical Privileges due to the application being deemed incomplete or the presence of an exclusive professional services contract.

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- a) Denial or revocation of one or more Clinical Privileges or failure to process an application for the Clinical Privileges due to the Practitioner's failure to comply with objective minimum or threshold criteria for the Clinical Privileges;
 - b) Any requirements imposed during a focused professional practice evaluation (FPPE) for an initial grant of Clinical Privileges
 - (2) Failure to advance from provisional status or failure to grant an extension of provisional status due to lack of required minimum activity;
 - (3) Collegial interventions and voluntary performance improvement plans;
 - (4) Restriction, denial or termination of a Clinical Privilege applicable to all similarly situated Practitioners regardless of competence;
 - (5) Probation that does not restrict the exercise of Clinical Privileges;
 - (6) Automatic actions under Section 7.3 of the Bylaws;
 - (7) A requirement of observation, consultation, or proctoring that does not require that the observer/consultant/proctor approve or always be present for the Practitioner to exercise Clinical Privileges;
 - (8) Issuance of a letter of warning, letter of reprimand, a requirement to obtain CME, counseling or treatment that does not prevent the Practitioner's exercise of Clinical Privileges, or any other type of corrective action that is not listed in Section 8.1 (a);
 - (9) Removal from emergency services call obligations, removal or recall from any elected or appointed position in Medical Staff leadership or on a Medical Staff or Hospital committee, or inability to exercise Clinical Privileges due to the presence of an exclusive professional services contract; and
 - (10) Failure to grant a request for leave of absence or an extension of an extension of the leave.
- (d) These procedural rights of review do not apply to any individuals other than Practitioners. The rights of Allied Health Professionals are as set out in Allied Health Credentials Policy and Procedure Manual.

8.2 PROCEDURAL RIGHTS OF REVIEW

- (a) Practitioners
All hearings and appellate reviews required or permitted under these Bylaws for Practitioners will be conducted in accordance with the notices, procedures, and safeguards set forth in the Hospital's Fair Hearing Plan attached hereto.

b) Basic Rights

The hearing shall include the following basic rights, as further detailed in the Fair Hearing Plan;

- 1) A hearing before an arbitrator, hearing officer, or a panel of individuals as detailed in Section 2.3 of the Fair Hearing Plan ("hearing committee");
 - 2) Representation by an attorney or other person of the Practitioner choice;
 - 3) Have a record made of the hearing by the Hospital, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation of the copy;
 - 4) Call, examine, and cross-examine witnesses;
 - 5) Present evidence determined to be relevant by the presiding officer regardless of its admissibility in a court of law;
 - 6) Submit a written statement at the close of hearing;
- And upon completion of the hearing:
- 7) Receive the written recommendation of the hearing committee, including a statement of the basis for the recommendations; and
 - 8) Receive the written decision of the Board, including a statement of the basis for the decision.

The Practitioner's right to the hearing will be forfeited if the Practitioner fails, without good cause, to appear at the hearing.

c) Mediation

Practitioners will also be afforded the right to mediation if required by Texas hospital licensing law in accordance with the procedures in the Fair Hearing Plan. [Texas Health & Safety Code Sec. 241.101 (d).] If a Practitioner requests mediation in connection with an Adverse Recommendation or Action, mediation must be conducted prior to conducting any hearing. Failure to request mediation prior to or at the time of requesting a hearing waives the Practitioner's right to statutory mediation.

8.4 RELEASE

By requesting procedural rights of review (or waiving those rights) in accordance with this Article VIII and the Hospital's Fair Hearing Plan, a Practitioner expressly releases from any liability for any damages or costs and expenses, including, but not limited to, attorney's fees and expenses in any manner arising out of or alleged to arise out those rights, all individuals and organization who, in good faith and without malice are involved with or take part in the hearing, appellate review proceedings, or mediation, or who provide information or documentary evidence for or during such proceedings. All recommendations, proceedings, evidence, and other information, whether written or oral, which are made or given under this Article VIII and the Hospital's Fair Hearing Plan shall remain privileged and confidential to the fullest extent permitted by applicable law and no such recommendations, proceedings, evidence, or other information shall be divulged to persons not involved in the proceedings or members of the Medical Staff, the Board, or officers of the Corporation. This release of liability is in addition to, and not in limitation of, any protections and immunities afforded by state and federal law.

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ARTICLE IX
OFFICERS, SECTION CHAIRMEN AND COMMITTEES

9.1 OFFICERS

(a) Qualifications of Officers

- (1) He must be an Active Medical Staff member in good standing; and
- (2) He must have demonstrated ability and have evidenced a desire for assuming responsibility through active participation in Staff matters and clinical practice at the Hospital.

(b) Medical Staff Officers

The Officers of the Medical Staff shall be the President/Chief of Staff, President-Elect, and Secretary-Treasurer. Beginning in December of 1990, the President/Chief of Staff, President-Elect, and Secretary-Treasurer shall be elected from the Active Medical Staff at the annual meeting of the Staff in accordance with the procedures specified in these Bylaws. Beginning in January 2000, the President and President-Elect shall hold office from January to December for two calendar years or until a successor is elected and takes office. The Secretary Treasurer shall hold office for one calendar year or until a successor is elected and takes office.

9.2 PRESIDENT/CHIEF OF STAFF'S DUTIES AND RESPONSIBILITIES

- (a) The President/Chief of Staff shall call and preside at all general Staff meetings. He/she shall appoint members to Staff committees and name the chairmen thereof where not specifically otherwise provided by these Bylaws. He/she shall be chairman of the MEC, and an Ex-Officio member of all other Staff committees. He/she shall be familiar with the clinical work done in the Hospital and the supervision of same. He/she shall work in close and full cooperation with the Chief Executive Officer, and be concerned with coordinating the efforts of the MEC and the Chief Executive Officer.
- (b) The President/Chief of Staff shall be the representative of the general Medical Staff to the MEC and, as such, shall have the responsibility to report back to the general Staff and to develop ways and means of maintaining good communications between the general Staff and the MEC.
- (c) The President/Chief of Staff shall be an ex-officio member of the Board and attend Board meetings, for the purpose of reporting on the activities of the Medical Staff and communicating the concerns of the Medical Staff Board and administration of the Hospital.

9.3 PRESIDENT-ELECT'S DUTIES AND RESPONSIBILITIES

The President-Elect, in the absence of the President/Chief of Staff, shall assume all of the President/Chief of Staff's duties and authorities. The President-Elect shall also be expected to perform such other duties as may be assigned to him/her by the President/Chief of Staff. The President-Elect will serve as chairman of the Physician's Quality Improvement Committee and any other committees as assigned by the President/Chief of Staff. The President-Elect will automatically succeed to the Office of the President/Chief of Staff for any reason and automatically become President/Chief of Staff for the calendar year following the year of his/her service as President-Elect.

9.4 IMMEDIATE PAST PRESIDENT/CHIEF OF STAFF'S DUTIES AND RESPONSIBILITIES

The Immediate Past President/Chief of Staff will serve as a member of the MEC and as an advisor to the President/Chief of Staff and will perform such other duties as may be reasonably assigned by the President/Chief of Staff, the Board, or the MEC.

9.5 SECRETARY-TREASURER'S DUTIES AND RESPONSIBILITIES

The Secretary-Treasurer shall keep accurate and complete minutes of all meetings on orders of the President/Chief of Staff, attend to all correspondence and perform such other duties as ordinarily pertain to that office or which may be assigned to him/her by the President/Chief of Staff. If there are funds of the Staff to be accounted for, he/she shall be responsible therefore. In the event of the absence of both the President/Chief of Staff and the President-Elect, the Secretary-Treasurer shall assume all of the President/Chief of Staff's duties and authorities.

9.6 VACANCIES

- (a) President/Chief of Staff Any vacancy in the office of the President/Chief of Staff shall be filled by the President-Elect for the unexpired term. The President-Elect shall then continue in office for the next succeeding term to which he/she would otherwise have succeeded had the vacancy in the office of President/Chief of Staff not occurred.

(b) Other Offices

Any vacancy in the offices of President-Elect or Secretary-Treasurer shall be filled from among the Active Staff members not then serving on the MEC by appointment by the MEC with approval of the Board. Any vacancy in the office of the Immediate Past President/Chief of Staff shall not be filled. Any President-Elect appointed hereunder shall not succeed to the office of President/Chief of Staff, but shall leave office at the end of the term of the President-Elect to whose vacancy he/she was appointed. If for any reason multiple vacancies occur, such that both the

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President/Chief of Staff and the President-Elect have been appointed hereunder, both the office of President/Chief of Staff and the President-Elect will be filled by election of the staff at the next annual meeting of the Staff.

9.7 RESIGNATION AND REMOVAL FROM OFFICE

(a) Resignation

Any officer of the Medical Staff may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

(b) Removal

Any officer of the Medical Staff may be removed, with permissible cause, by a written vote of two-thirds (2/3) of a quorum of the members of the Staff eligible and qualified to vote for Staff offices, such vote being taken at a special meeting called for that purpose of a regular meeting where notice of such proposed removal vote was sent by the MEC to all members of the Staff eligible and qualified to vote for staff offices at least twenty (20) days prior to such meeting. The presence of fifty (50) percent of such qualified members of the Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of removing an officer of the Staff. Permissible cause to remove any Medical Staff officer shall include, without limitation, the following:

- (1) failure to perform the duties of the position held in a timely and appropriate manner; and
- (2) failure to continuously satisfy the qualifications for the position.

9.8 SECTION AND SUBSECTION CHAIRMEN

(a) Qualifications for Chairman and Chairman-Elect of a Section or Sub-Section

- (1) He must be an Active Medical Staff member in good standing; and
- (2) He must have demonstrated ability and have evidenced a desire for assuming responsibility through active participation in Staff matters and clinical practice at the Hospital, and
- (3) Must be Board certified in his/her specialty or have actively practiced for a minimum of ten (10) years.

(b) Election

- (1) Each chairman-elect of a section shall be elected by the respective section at the October meeting. Beginning in January 2000, the Chairmen of Sections shall hold office from January to December for two terms (calendar years) or until a successor is elected and takes office. The Chairman-elect will become Chairman of such Section following the time period of his/her service as Chairman-elect.
- (2) Each chairman-elect of a subsection shall be elected by the respective subsection in October of each Medical Staff year and hold office from January 1 to December 31 of the immediately succeeding Medical Staff year. The chairman-elect will become the chairman of such subsection for the Medical Staff year immediately following the end of his/her term of office as chairman-elect of such subsection. Such chairman shall hold office for a term of one year or until a successor is elected and takes office.

(c) Section Chairman Duties and Responsibilities

In accepting the position of section chairman, such Staff member assumes the following duties and responsibilities:

- (1) to implement, coordinate and supervise the basic functions and responsibilities of his/her section as specified in Section 5.4;
- (2) to preside at all meetings of the section, and to assure that the quality and appropriateness of patient care provided within the section are monitored and evaluated, and to insure that a record of each such meeting in minute form is developed and maintained;
- (3) to participate in all professional activities of the Medical Staff where his/her attendance and assistance would be helpful;
- (4) to provide input to the MEC and the Board regarding section and patient care matters;
- (5) to represent his/her section on the MEC and to present any section matters deemed appropriate;
- (6) to be thoroughly familiar with the Bylaws and the Staff Rules and Regulations and the requirements of the Hospital's accrediting agency; and
- (7) recommend to the Medical Staff the criteria for clinical privileges in the section and recommend clinical privileges for each member of the section;
- (8) to make recommendations to the Credentials Committee regarding initial appointments and reappointments to the Medical Staff;
- (9) to see that the clinical activities of the section are reviewed at quarter-annual meetings, including the review of the Quality Improvement activities as reviewed by the Physician Quality Improvement Committee and all other relevant reports of the Hospital utilization review, infection control, patient safety programs, and risk management activities;
- (10) to discuss problem cases that are brought to the attention of the section chairmen with the physician in charge and suggest treatment or consideration as agreeable to the attending physician;
- (11) make appropriate reports to the Physician's Quality Improvement Committee with respect to the professional performance of all practitioners and Allied Health Professionals holding Clinical Privileges or Specified Services in the section;

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- (12) to appoint such assistants and designees as deemed appropriate in order to assist the chairman in carrying out his/her duties and responsibilities as specified in these Bylaws.
 - (13) perform such other duties commensurate with the office as set out in these Medical Staff Bylaws of any of the related manuals, and, where applicable, in a contract with the Corporation and as may from time to time be reasonably requested by the President/Chief of Staff, the MEC, or the Board; and
 - (14) continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in this Section; and
 - (15) the coordination and integration of interdepartmental and intradepartmental services; and
 - (16) the development and implementation of policies and procedures that guide and support the provision of services; and
 - (17) the recommendations for a sufficient number of qualified and competent persons to provide care/service; and
 - (18) the maintenance of quality control programs as appropriate; and
 - (19) the orientation and continuing education of all persons in the section; and
 - (20) recommendations for space and other resources needed by the section; and
 - (21) assesses and recommends to the relevant hospital authority off-site sources for needed patient care services not provided by the section or the organization.
- (d) Section Chairman-Elect Duties and Responsibilities
- In the absence of the chairman of a section, the chairman-elect shall assume all of such chairman's duties, responsibilities, and authorities. The chairman-elect of each section shall also perform such other duties as may be assigned to him/her by the chairman of his/her section. The chairman-elect of each section shall be a member of the Physician's Quality Improvement Committee.
- (e) Subsection Chairman Duties and Responsibilities
- (1) to implement, coordinate and supervise the basic functions of his/her subsection as determined by the applicable Staff section;
 - (2) to preside at all meetings of the subsection, and to see that medical subjects, current cases, and problems are discussed so as to constitute a thorough review of the clinical work performed within the subsection since the last meeting, and to insure that a record of each such meeting in minute form is developed and maintained;
 - (3) to participate in all professional activities of the Medical Staff where his/her attendance and assistance would be helpful;
 - (4) to provide input to the subsection's applicable section regarding subsection, section and patient care matters;
 - (5) to be thoroughly familiar with the Bylaws and the Staff Rules and Regulations and the requirements of the Hospital's accrediting agency; and
 - (6) to appoint such assistants and designees as are deemed appropriate in order to assist him/her in carrying out his/her duties and responsibilities as specified in these Bylaws;
 - (7) to perform such other duties commensurate with the office or as set out in these Medical Staff Bylaws, or any of the related manuals, and, where applicable, in a contract with the Corporation, and as may be from time to time reasonably requested by the President/Chief of Staff, the chairman of the section of which the subsection is a subdivision, the MEC, or the Board.
- (f) Vacancies
- (1) A vacancy occurring in a Section Chair position shall be filled by the Chair-elect of that section. The MEC shall appoint qualified members to fill Chair-elect vacancies or vacancies occurring simultaneously in both the Chair and Chair-Elect positions, after consultation with active section members in good standing.
- (g) Resignation and Removal from Office
- (1) Any chairman or chairman-elect of a section or subsection may resign at any time by delivering a written resignation to the MEC. Such resignation, which may or may not be contingent on formal acceptance, takes effect on the date of receipt by the MEC or at any later time specified in such resignation.
 - (2) Any chairman or chairman-elect of a section or subsection may be removed with permissible cause, by a written vote of two-thirds of a quorum of the members of the section or subsection eligible to vote for section or subsection offices as the case may be, such vote being taken at a special meeting called for such propose or at any regular meeting. The presence of fifty percent (50%) of such qualified members of a section or subsection at any regular or special meeting shall constitute a quorum for the purpose of removing any chairman or chairman-elect of a section or subsection. A vote to remove a section or subsection chairman or chairman-elect shall not be taken at a regular meeting of the affected section or subsection unless written notice of such removal vote has been sent to all members in good standing of such section or subsection at least twenty (20) days prior to such vote. Permissible cause to remove any section or subsection officer shall include without limitation any of the following:
 - (A) failure to perform the duties of the position held in a timely and appropriate manner; and
 - (B) failure to continuously satisfy the qualifications for the position.

9.9 STAFF COMMITTEES

Staff committees shall either be standing or special in nature, and the Chief Executive Officer of his/her designee shall be a non-voting ex-officio member of each. All committees shall record minutes of their meeting and make a report of each meeting to the MEC. The President/Chief of Staff and President-Elect of the Medical Staff shall be ex-officio voting members of each committee, except in each case where only the President/Chief of Staff or President-Elect is

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specifically named as a member of a committee below, in which event only the officer so named shall serve on such committee. The President/Chief of Staff or President-Elect shall be a voting member of such committee, as the case may be, unless otherwise specified to the contrary.

(a) Standing Committees

The standing committees of the Medical Staff shall be as follows:

- (1) the Medical Executive Committee;
- (2) the Credentials Committee;
- (3) the Quality Improvement Committee;
- (4) the Utilization Review Committee;
- (5) the Medical Staff Education Committee;
- (6) the Pharmacy and Therapeutic;
- (7) the Infection Prevention Committee;
- (8) the Emergency Services/Disaster Committee;
- (9) the Cardiovascular/Critical Care Committee;
- (10) the Radiation Safety and Isotope Committee;
- (11) the Cancer Committee;
- (12) the Breast Cancer Committee;
- (13) the Bylaws Committee;
- (14) the Nominating Committee;

(b) Composition and Duties of Standing Staff Committees

(1) Medical Executive Committee

- (A) The Medical Executive Committee shall consist of the President/Chief of Staff, the immediate Past President/Chief of Staff, the President-Elect, the Secretary-Treasurer, the section chairmen, the chairman of the Credentials Committee, and four (4) other members of the Active Medical Staff to be elected by the members of the Active Medical Staff at the annual General Staff meeting. In addition, the Medical Director of Pathology, Medical Director of Emergency Services, Medical Director of Psychiatry and Chairmen of Cardiovascular/Critical Care Committee, Pharmacy and Therapeutic Committee and Infection Prevention Committee will be appointed by the Chief of Staff as voting ex-officio members.
- (B) The four elected members of the Active Medical Staff shall each serve a term of three (3) years with their terms to be staggered in a manner determined by the Medical Executive Committee.
- (C) The duties of the MEC shall be as follows:
 - (i) to coordinate the activities and general policies of the various sections;
 - (ii) to act for the Staff as a whole under such limitations as may be imposed by the Staff;
 - (iii) to receive and act upon the reports and recommendations of sections and subsections, the standing Staff committees and such other committees as the Medical Staff may designate;
 - (iv) to make reports from time to time to Physicians Quality Improvement Committee of any patient care problems coming to the attention of the MEC;
 - (v) to meet once a month but no less than ten (10) times per year and maintain a permanent record of its proceedings and actions;
 - (vi) to act for the Medical Staff in conducting special interviews, hearings, and appeals proceedings involving members of the Medical Staff or AHPs, and applicants seeking appointment thereto as set out in the Fair Hearing Plan;
 - (vii) to provide as a liaison between the staff and the Chief Executive Officer and other officers of the Corporation, the Hospital administration, and the Board;
 - (viii) function as the Regulatory Accreditation Committee and keep the entire professional staff informed concerning the program of the Regulatory Agency, the current accreditation status of the Hospital, and the factors influencing that status;
 - (ix) the MEC may act for the Staff in the intervals between Medical Staff meetings except as expressly provided otherwise herein;

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- (x) implement policies of the Staff not otherwise the responsibility of the sections;
 - (xi) make recommendations to the Board concerning the structure of the Staff, the mechanism used to review credentials to delineate individual Clinical Privileges and Specified Services as provided in the Credentials Manual, and to recommend individuals for the Staff membership or the performance of Specified Services as an AHP, to make recommendations with respect to the delineation of Clinical Privileges for Staff Members and for eligible applicants for Staff membership, organization of Quality Improvement activities of the Staff and the evaluation and revision of same, and the mechanisms for terminating Medical Staff membership or AHP status and the plan for providing a fair hearing; and
 - (xii) there is a mechanism to assure the same level of quality of patient care by all individuals within Medical Staff sections, across sections and between members and nonmembers of the Medical Staff who have delineated clinical privileges.
- (2) Credentials Committee
 - (A) The Credentials Committee shall consist of a minimum of six (6) Active Medical Staff members with all Standing Sections represented, one (1) of whom shall be appointed as Chairman by the President/Chief of Staff.
 - (B) The elected members shall each serve a term of three (3) years with their terms to be staggered in a manner determined by the MEC so that one-third (1/3) of such elected members' terms will expire each Medical Staff year. The Corporation's Medical Staff Coordinator and the Chief Executive Officer shall be non-voting ex-officio members of the Credentials Committee.
 - (C) The duties of the Credentials Committee shall be as follows:
 - (i) to evaluate the credentials of all applicants for Staff membership, and to report recommendations and findings in conformity with these Bylaws to the MEC;
 - (ii) to act as a fact-finding committee whenever the professional or moral ethics of a Staff member are under investigation;
 - (iii) to review the qualifications of each Staff member applying for additional Privileges, reappointments, or reassignments in the various sections as provided in these Bylaws;
 - (iv) maintain a current credential file for each Medical Staff member; and
 - (v) meet on call, but not less than quarter-annually.

(3) Quality Improvement Committee

Membership

QIC Composition – The QIC will be comprised of voting members from the following areas: the Chair-Elect from each Section and at large members who are nominated by the QIC chair and approved by the MEC. In the event there is no acting Section Chair-Elect, or the Section Chair-Elect fails to fulfil his/her duties, the QIC Chair may recommend a section representative to the MEC for approval. The representative will be a voting member of the QIC: until a Section Chair-Elect is elected and takes office [see Section and Subsection Chairmen 9.8 (b)] or if deemed appropriate by the QIC, as an at-large member. Practitioners from other specialties may be invited to the meeting as needed (rev. 12/20).

Ex-Officio Members – The Chief Quality Officer (CQO), Quality support staff, CNO and the VP of Quality and Risk Management are ex-officio non-voting members of the QIC.

Appointment and Terms – Voting members will be elected by the Sections or appointed by the COS and approved by the MEC for two-year terms.

Voting members may be selected for additional terms without limit.

QIC Chair – The QIC Chair will be the Chief of Staff-Elect of the Medical Staff. The QIC Chair will appoint a Vice Chair to serve if the chair is not available or has a conflict of interest.

Member Responsibilities –

To maintain membership, QIC members will be expected to attend at least two-thirds (2/3rds) of the scheduled QIC meetings over a twelve month period and perform assigned case reviews according to QIC policies. Members failing to fulfill their responsibilities will be considered for replacement by the process used for committee appointment. Members are expected to participate in appropriate educational programs provided by the Medical Staff to increase their knowledge and skill to perform their responsibilities.

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If a member of the medical staff who is not a QIC member is requested to perform a case review, it is that individual's responsibility to perform that review in a timely manner according to QIC policies.

Meetings

The QIC will meet at least six (6) times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 30% of the voting QIC members at a regularly scheduled meeting. A majority will consist of a majority of voting QIC members present.

Scope

The duties of this committee shall be as follows:

- The QIC will be responsible for evaluating all areas of practitioner competency for physicians and other practitioners with delineated privileges providing care at a Baptist Hospitals of Southeast Texas (BHSET) hospital, under the responsibility of the Medical, unless otherwise indicated in this charter. The evaluation will be based on information provided to the QIC from various Hospital and Medical Staff sources.
- Although the QIC will be a source of competency data, credentialing and privileging decisions are the responsibility of the Section Chairs, the Credentialing Committee, the Medical Executive Committee, and the Board of Trustees.
- While performance measurement and evaluation for hospital systems and processes are the responsibility of the appropriate hospital committee or department, the QIC will identify and communicate those system and process issues affecting practitioner performance.

Responsibilities

The primary responsibilities of the QIC are:

1. Measurement System Management
2. Evaluation of Practitioner Performance
3. Improvement Opportunity Accountability
4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

These responsibilities are described in detail below:

Measurement System Management

- At least annually, and as needed, review for effectiveness medical staff indicators, targets, practitioner attribution and screening methods and recommend changes to the MEC. This will be done in collaboration with the Section Chairs.
- The QIC will have the authority to develop and implement specialty-specific indicators if not provided by the Sections in a reasonable timeframe.
- Design and approve studies when necessary to analyze aggregate practitioner performance.

Evaluation of Practitioner Performance

- **Evaluation of Individual Cases**
 - Assign the appropriate reviewer(s) or need for external review for cases identified for peer review as described in medical staff policies
 - Make determinations regarding individual practitioner improvement opportunities based on individual or multiple case reviews.
 - Recommend focused evaluations when necessary to further define if an improvement opportunity exists.
 - Recognize practitioner excellence under difficult clinical circumstances by practitioners.
 - Identify potential hospital systems affecting practitioner practice or other professional practice improvement opportunities.
- **Evaluation of Rate and Rule Data for OPPE**
 - Assure systematic, timely review of medical staff rule and rate indicators and OPPE data for individual practitioner outliers as described in the OPPE/FPPE policy.
 - When outliers are identified, assure that the data is adequately analyzed and potential improvement opportunities are appropriate identified.
 - Evaluate rule and rate data for medical staff wide improvement opportunities or hospital system issues affecting physician practice.

Improvement Opportunity Accountability

- When individual improvement opportunities are identified through case review or OPPE data, assure that the appropriate individuals are notified and a reasonable improvement plan is developed as described in the OPPE/FPPE policy.
- Monitor and evaluate the effectiveness of practitioner improvement plans.
- When authorized by the MEC, develop, implement and monitor performance improvements for medical staff wide improvement opportunities.
- When hospital system issues affecting physician practice are identified, the QIC will communicate the concern to the appropriate hospital leader or committee and request a response regarding efforts to address the issue.

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Oversight of Other Medical Staff Practitioner Performance Evaluation Committee

- Some medical staff departments or committees may continue to evaluate practitioner performance for professional quality control or to collect data for OPPE. These committees will report to the QIC any relevant practitioner specific rule or rate data through the OPPE process. Cases meeting review indicator criteria will be referred to the QIC for evaluation.
- Medical Staff evaluation of practitioner performance for educational purposes (i.e. M&M conferences) will be considered part of the medical staff peer review function. However, the discussion results are not placed in the practitioner's quality file and any practitioner specific concerns are referred to the QIC for formal evaluation.
- The Trauma Committee performs case review functions required by ACS standards. Cases with practitioner care issues as defined by review indicators will be referred to the QIC for formal evaluation unless the Trauma Committee is delegated to perform such reviews.

Specific Medical Quality Related Functions outside of the QIC scope

There are other medical staff quality related functions that are not performed by the QIC, but the function of the applicable committee defined in the Medical Staff Bylaws (i.e. Infection Prevention Committee, Pharmacy and Therapeutics Committee).

(4) Utilization Review Committee

This committee shall consist of the Medical Director for the Care Management Department as Chairman and at least one (1) additional member of the Active Medical Staff. The Hospital's Director of Care Management and a Nursing representative shall be appointed as voting ex-officio members of the committee.

The committee shall plan to meet no less than quarterly each calendar year and minutes will be kept of all such meetings.

The duties of this committee shall be as follows:

- (A) to assure that inpatient services provided at the Hospital are medically necessary and provided in a cost-effective manner;
- (B) to increase effective utilization of inpatient services at the Hospital through an educational approach involving studies of patterns of care within the Hospital, or on a regional or statewide basis; and
- (C) to establish and carry out a program of utilization review for all patients at the Hospital to assess medical necessity and cost of patient care at the Hospital.
- (D) review all utilization related data, minutes, reports, and results from Medical Staff sections, committees, and departments;
- (E) summarize all utilization related data for presentation to the Medical Executive Committee and Board of Trustees, at least quarter-annually;
- (F) refer appropriate information to individual services, sections, subsections, or committees for discussion and action;
- (G) assist in identifying and evaluating problems or opportunities for improvement;
- (H) monitor progress in resolving identified or potential problems or opportunities for improvement;
- (I) identify areas in need of further study and recommend appropriate study methods or procedures; and
- (J) oversee the annual appraisal of the Utilization Review program and written plan.

(5) Medical Staff Education Committee

This committee shall assume responsibility for planning and directing medical education functions designed to meet needs identified by the Medical Staff and Hospital Quality Improvement Program. Medical Staff funding in support of continuing medical education shall be addressed under Rules and Regulations and in the Credentials Manual. The Committee shall collaborate with the Hospital's Department of Medical Education concerning the references available for resource. The Committee shall meet on an ad hoc basis. Committee members shall consist of at least three (3) members of the Active Staff. Committee administrative operations shall be consolidated under the auspices of the Committee Chairperson. A representative from Administration will serve as a non-voting ex-officio member of the Committee.

(6) Pharmacy and Therapeutic Committee

This Committee shall consist of at least three (3) members of the Active Medical Staff, a representative of the Hospital pharmacy and a representative of the Hospital nursing staff and other appropriate Hospital personnel appointed by the President/Chief of Staff. This

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Committee shall advise the MEC and the Hospital pharmacy on all matters relating to drug utilization in the Hospital. This Committee shall meet as required, but at least quarter-annually, and keep minutes of all such meetings. The representative of the Hospital pharmacy and nursing staff shall be appointed by the President/Chief of Staff as voting members of the Committee.

7) Infection Prevention Committee

This Committee shall consist of at least three (3) members of the Active Medical Staff, the Hospital's Infection Prevention Nurse, the Supervisor of Microbiology pharmacy and other appropriate Hospital personnel appointed by the President/Chief of Staff as voting members. This Committee shall advise the MEC and the Corporation on all matters relating to the control of infections in the Hospital. The Committee shall meet as required, but at least quarter-annually, and keep minutes of all such meetings.

8) Emergency Services/Disaster Committee

This Committee shall consist of at least three members of the Active Medical Staff, a member of the Radiology subsection and a member of the Pathology subsection, a representative of the Hospital nursing staff and a representative of the Emergency Service Medical Staff, all as voting members. This Committee shall advise the MEC and the Emergency Service Staff on all matters relating to the operation of the Emergency Services at the Hospital. This Committee shall also advise the Hospital and the MEC with respect to the development and maintenance of appropriate civil defense and disaster plans for the Hospital. It shall meet on an ad hoc basis and keep minutes of all such meetings. Meetings may be held jointly with the Civil Defense and Disaster Committees from other hospitals.

(9) Cardiovascular/Critical Care Committee

This Committee shall consist of at least three (3) members of the Active Medical Staff appointed from among Physicians who actively practice cardiology, cardiovascular surgery, peripheral vascular surgery, cardiac anesthesia and pulmonology. In addition, the Committee shall have one (1) member who shall be a member of the Active Medical Staff who is a member of the Pathology subsection and one (1) member of the Radiology subsection. In addition, the Committee shall have one (1) member of the Active Medical Staff who practices primary care and/or internal medicine. In addition, representatives of the Hospital nursing staff and other appropriate Hospital personnel shall be appointed by the President/Chief of Staff as voting members.

The Committee shall meet no less than quarter-annually; provided, however, the Committee shall perform quality assessment functions in reviewing the performance of staff members holding cardiovascular privileges on a quarterly basis. Minutes will be kept of all such meetings.

The purposes and duties of the Committee shall be as follows:

- (A) The Committee shall function as an advisory committee to the Medical Staff and its respective committees in all matters concerning the practice of Cardiology in the Hospital. The Committee shall develop and actively carry on a program of quality assessment in all phases of Cardiology and Cardiovascular Surgery and also shall conduct regular mortality and morbidity conferences.
- (B) The Committee shall act as an advisory committee to the Hospital administration in those matters concerning the practice of Cardiology and shall act as an advisory committee in those functions pertaining to the development of new Cardiology services and programs in the Hospital.
- (C) The Committee shall assist and advise the Hospital and MEC on matters pertaining to the operations of the Hospital critical care units.

(10) Radiation Safety and Isotope

This Committee shall consist of at least three (3) members of the Active Medical Staff, one of whom shall be a Hospital Radiologist practicing at the hospital. The Committee shall also consist of the Director of the Hospital Imaging Department, the Hospital Radiation Safety Officer the physicist, technical representatives from the Imaging Department, the Cancer Institute and the Cath Lab; who shall be appointed as voting ex-officio members. This Committee shall advise the MEC and the Radiology subsection on all matters pertaining to radiation protection. It shall meet as required, but at least quarter-annually, and keep minutes of all such meetings.

(11) Cancer Committee

The Committee membership includes multidisciplinary physician members from the diagnostic and therapeutic specialties, as well as allied health professionals involved in the care of cancer patients. Membership, it will be noted, shall conform to the accreditation requirements of the American College of Surgeons.

The Cancer Committee responsibilities include the following:

- * develops and evaluates the annual goals and objectives for the clinical, educational and programmatic activities related to cancer

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- * promotes a coordinated, multidisciplinary approach to patient management
- * ensures that educational and consultative cancer conferences cover all major sites and related issues
- * monitors quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes,
- * promotes clinical research
- * supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting
- * performs quality control of registry data
- * encourages data usage and regular reporting
- * ensures content of the annual report meets requirements
- * publishes the annual report of the following year which meets the requirements set forth by the American College of Surgeons Commission on Cancer (CoC)
- * upholds medical ethical standards
- * meets as often as necessary to accomplish its functions, at least quarterly

(10) Breast Cancer Committee

The Committee is multidisciplinary, and serves as a sub-committee of the Cancer Committee. The Breast Program Leadership Committee (BPLC), through the designated Breast Program Director (BPD) is (at least) an ad-hoc member of the Cancer Committee. The BPD must be a board-certified (or board-eligible) physician experienced in the on-going coordination of care for breast cancer patients. The role of the BPLC/BPD is as follows:

- The required membership of the BPLC will be in compliance with the standards of the Commission on Cancer and the National accreditation Program for Breast Centers
- The BPD will provide direct oversight of the function of the Breast Care Team (BCT)
- The BCT will, at a minimum, consist of physicians representing surgery, reconstructive surgery, radiology, pathology, medical oncology and radiation oncology, in addition to clinical staff and other breast program personnel.
- The BPLC, in conjunction with the BPD, plans, develops, implements and evaluates all activities of the breast cancer program

(11) Bylaws Committee

This Committee shall consist of at least three (3) members of the Active Medical Staff who shall advise the MEC on all matters pertaining to these Bylaws, and Regulatory Agency requirements. It shall meet on an ad hoc basis and keep minutes of all such meetings.

(14) Nominating Committee

This Committee shall consist of the President/Chief of Staff, Immediate Past President, and the President-Elect. The Committee shall nominate one (1) member of the Active Staff for each Medical Staff office, each open Staff position on the Medical Executive Committee, and each open Staff position on the Credentials Committee and shall meet annually at least six (6) weeks prior to the Annual Staff Meeting and present the names to the MEC and send notice of such nominations to the Medical Staff at least three (3) weeks prior to the Annual Staff Meeting and present the same to the Staff members at the Annual staff meeting.

(c) Special Committees

The President/Chief of Staff may appoint special committees as may be required. Such committees shall confine their work to the purposes for which they were appointed, and for the term specified.

(d) Committee Appointments

All voting committee members whether of standing or special committees shall be appointed by the President/Chief of Staff, unless otherwise specified by these Bylaws, from among members of the Medical Staff. Ex-officio Members of any Medical Staff committee shall hold their place on such committees by virtue of positions held with the Corporation, the Hospital, or the Medical Staff and shall be members of committees to which such ex-officio members are assigned under these Bylaws only for so long as such ex-officio members hold such office. Ex-officio committee members shall not have the power to vote unless expressly provided otherwise in this Article IX. At the time any ex-officio members ceases to hold the office which confers membership on a particular committee, he/she shall automatically terminate his/her membership on such committee. In the same manner appointment to a position which provides an ex-officio membership on a committee authorized by these Bylaws shall work as an automatic appointment to such committee.

In addition, the President/Chief of Staff may appoint such other non-voting members or agents to any of the standing or special committees authorized by these Bylaws as he/she shall from time to time deem appropriate in order to assist such committees in more effectively carrying out their duties, including, but not limited to, Allied Health Professionals, representatives of the administration of the Hospital, officers of the Corporation, experts, including physicians, attorneys, at risk managers, insurance consultants, safety experts and engineers, who are not members of the Medical Staff but who have special skill and knowledge in particular areas of medicine, management, administration, risk management, insurance, law, federal and/or state regulations, or other areas, who could be of benefit to the functioning of the particular committee to which such special non-voting members are appointed.

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(e) Term

Each member of a Medical Staff committee, whether standing or special, shall serve for the Medical Staff year for which he/she is appointed. If a committee member is appointed during a Medical Staff year for the then current Medical Staff year, his/her term shall expire on December 31st of that year or the date his/her successor is appointed, whichever is later, unless otherwise specified by these Bylaws. Any appointment to a special committee or appointment of a special non-voting member as provided above to any committee may be for a specified term which is longer or shorter than the term specified above or may be for the duration of a particular assignment, task, or project.

(f) Chairman

One (1) member of each committee of the Medical Staff, whether standing or special, shall be designated as chairman by the President/Chief of Staff, unless otherwise specified by these Bylaws.

(g) Vacancies

Vacancies in the membership of any Staff committee may be filled by appointments made in the same manner as provided in the case of the original appointments, unless otherwise provided in these Bylaws, for the unexpired term of such committee membership.

(h) Removal

Any committee member except a serving ex-officio member may be removed by the vote of the MEC, with or without cause.

(i) Quorum and Voting

Thirty (30) percent or more of the total voting membership of a Staff committee (whether standing or special) shall constitute a quorum (but never less than two (2) members) and the act of a majority of the voting members present at a meeting at which a quorum is present shall be the act of the committee. Action may be taken without a meeting by unanimous consent of each member entitled to vote, which consent may be obtained in writing or by telephonic communication which is subsequently reduced to written resolution and signed by the chairman of the committee.

ARTICLE X
MEETINGS

10.1 THE ANNUAL STAFF MEETING

The annual meeting of the Staff shall be the last regular Staff meeting before the end of the calendar year. At this meeting the retiring officers and Staff committees shall make each reports as may be desirable and officers, and elective committee members for the ensuing year shall be elected.

10.2 REGULAR STAFF MEETINGS

Business of the general Staff shall be conducted by the Active Staff at the annual Staff meeting, which shall be held in December of each Staff year. Attendance is encouraged as provided in Section 10.5 of these Bylaws. At such meetings a report of the medical work of the Hospital shall be presented by the Medical Executive Committee and other Staff committees concerned therewith.

10.3 SECTION AND SUBSECTION MEETINGS

The various sections of the Medical Staff shall meet at least two (2) times a year on a semi-annual basis to review the report of the Physician Quality Improvement Committee as well as all other relevant reports and information required by sections with respect to patient care provided by such section as described in Section 5.4, including a review of all patient deaths and unusual complications with respect to patients receiving care in the Hospital. A report of findings and recommendations shall be made to the Medical Staff at the annual Staff meeting. Subsections of Surgery shall meet on an ad hoc basis, immediately following the Surgery Section for the purpose of establishing its own criteria for the granting of clinical privileges and other functions as described in Section 5.4.

10.4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the President/Chief of Staff, shall be called at the request of the Board or the Medical Executive committee, or may be called at the written request of any five Active members of the Medical Staff. No business shall be transacted at any special meeting except that stated in the notice calling for the meeting. Notice of any special meetings shall be posted on the bulletin board in the Staff room at least 48 hours before the time set for the meeting.

10.5 ATTENDANCE AT MEETINGS

(a) Members of the Active Medical Staff are encouraged to attend a majority of the regular meetings of the Staff and/or their section and/or subsection.

Members of the Medical Executive Committee and Credentials Committee are expected to attend a minimum of 75% of their regularly scheduled meetings.

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Special appearance requirements: Any Staff member involved in the treatment of a case under review or involved in a special investigation may be required to attend a meeting to discuss the issue, provided that the individual was given reasonable advance notice. Failure on the part of a medical staff member to comply with this special appearance requirement will, after two written notices sent by certified or registered mail return receipt requested, be deemed a resignation of medical staff membership and clinical privileges.

- (b) Members of the Honorary and Limited categories of the Medical Staff shall not be required to attend meetings, but it is expected that they will attend and participate in these meetings as well as adhere to the special appearance requirements as specified in Section 10.5 (a).

10.6 QUORUM

The body of members of the Active Medical Staff present at an appointed meeting shall constitute a quorum.

10.7 AGENDA

- (a) The agenda at any regular Staff meeting shall be:
Business:

- (1) Call to order;
- (2) Reading of the minutes of the last regular and of all special meetings and approval of minutes;
- (3) Old Business;
- (4) Communications;
- (5) New Business;

Quality Improvement:

- (6) Review of the analysis of the clinical work of the Hospital including the report of the section's Quality Improvement Committee;
- (7) Reports of standing and of special Medical Staff committees;
- (8) Discussion and recommendations for improvement of the performance of the Hospital; and
- (9) Adjournment.

- (b) The agenda at special meetings shall be:

- (1) Reading of the notice calling the meeting;
- (2) Transaction of the business for which the meeting was called; and
- (3) Adjournment.

10.8 VOTING

Unless otherwise expressly required by these Bylaws, every question shall be decided by a majority vote of those present and eligible to vote at the annual Staff meeting, any regular Staff meeting, any section meeting, or any subsection meeting at which a quorum is present. Any action of a section or subsection or Medical Staff committee may be taken without a meeting if consented to in writing by all of the members entitled to vote at any such meeting of such section or subsection or Medical Staff Committee.

ARTICLE XI
RULES AND REGULATIONS

The Medical Executive Committee shall recommend such Rules and Regulations as may be necessary for the proper conduct of the work of the Medical Staff and to implement in more detail the policies and procedures set out in these Bylaws. The Medical Executive Committee may recommend amendments to, additions to, or repeal of all or any part of these Rules and Regulations. Such Rules and Regulations, and any amendments thereto, shall be a part of these Bylaws, and shall become effective when approved by the Board and announced to the General Staff. The MEC shall also adopt (and may amend) an appropriate Credentials Policy and Procedure Manual, Fair Hearing Plan, and a Medical Screening, Consultations, Treatment, and Transfer Policy, and any amendments thereto and shall become effective when approved by the Board.

ARTICLE XII
BYLAW AMENDMENTS

12.1 PROCEDURE FOR AMENDING BYLAWS

- (a) The Medical Executive Committee may recommend amendments to, additions to, or repeal all or any part of these Bylaws. The MEC shall submit its proposals, as well as the Bylaws Committee's recommendations, to the Medical Staff in accordance herewith.

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- (b) Such proposals and recommendations shall be considered by the Medical Staff at its next regular meeting, or at a special meeting. Any amendments, additions, or repeals of these Bylaws submitted to the Medical Staff may be adopted by a two-thirds (2/3) vote of the Active Staff members present at such meeting when a quorum exists, and shall become effective when approved by the Board.
- (c) When a quorum is not present at any meeting of the Medical Staff at which any amendment, addition to, or repeal of the Bylaws (each hereinafter referred to as a "Bylaw Amendment") is considered, the Bylaw Amendment shall be submitted to the Medical Staff by mailed written ballot as set out in this Section 12.1(c). The MEC shall cause a written ballot setting out the proposed Bylaw Amendment to be sent to each member of the Medical Staff entitled to vote thereon at the address for such member then shown in the records of the Medical Staff as the address for such member. Each ballot shall contain a place that a member can mark to vote for or against the proposed Bylaw Amendment. The proposed Bylaw Amendment shall be adopted by the Medical Staff if a majority of the written ballots returned to the MEC within thirty (30) days after such ballots are mailed vote for the proposed Bylaw Amendment and the MEC receives ballots within such thirty (30) day period from a sufficient number of Medical Staff members to constitute a quorum at a regular or special meeting of the Medical Staff. If a sufficient number of the members of the Medical Staff to constitute a quorum do not submit ballots within said thirty (30) period, the Bylaws Amendment shall be deemed rejected.

12.2 NOTICE TO MEDICAL STAFF

No amendment, addition, or repeal of these Bylaws shall be voted upon by the Medical Staff, unless specific written notice of such amendment, addition, or repeal has been given by the MEC, by mail or otherwise, to the Active members of the Staff at least three weeks prior to the meeting at which such action will be taken.

ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 SPECIAL DEFINITIONS

For purposes of this Article, the following definitions shall apply:

- (a) "Information" means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in subsection 13.5.
- (b) "Malice" means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
- (c) "Practitioner" means a Staff Member or applicant for Staff membership.
- (d) "Representative" means the governing or advisory board of any hospital, including without limitation, the Board of the Corporation, and any director, or committee thereof; the Chief Executive Officer or his/her designee and any other officer of the Corporation; registered nurses and other employees of any hospital including the Hospital; a medical staff organization and any member, officer, clinical unit, committee, or subcommittee thereof including this Medical Staff, and any individual authorized by any of the foregoing to perform any specific information gathering, analysis, use or disseminating functions.
- (e) "Third Parties" means both individuals and organizations providing information to any Representative.

13.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Staff membership or by applying for or exercising Clinical Privileges or providing Specified Services in the Hospital, a Practitioner or AHP:

- (a) authorizes any representative, the Corporation, or the Medical Staff to solicit, provide, and act upon Information bearing on his/her professional ability and qualifications;
- (b) agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article;
- (c) acknowledges that the provisions of this Article are express conditions to this application for, or acceptance of, Staff Membership and the continuation of such membership and to his/her exercise of Clinical Privileges or provisions of Specified Services at the Hospital;
- (d) agrees to appear at the Hospital or at other designated locations for interviews with regard to his/her application;
- (e) gives his/her authorization to Representatives to consult with Third Parties who have been associated with the applicant, or who may have information bearing on his/her competence, character, qualifications, or health status;
- (f) gives his/her consent to the release of Information from all third Parties, having any Information bearing on the applicant's competence, character, qualifications or health status, including (without limitation) the applicant's present and past professional liability insurance carriers;

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- (g) gives his/her release from any liability of all Representatives for their acts performed in good faith and without Malice in connection with evaluating the applicant, his/her credentials, and his/her application;
- (h) gives his/her release from any liability of all Third Parties who provide Information, including otherwise privileged or confidential Information, to any Representative in good faith and without Malice concerning the applicant's competence, professional ethics, character, physical and mental health status, emotional stability, and other qualifications for Staff appointment and Clinical Privileges or Specified Services;
- (i) gives his/her pledge to provide for the continuous care of his/her patients, and to abide by these Bylaws and the Staff Rules and Regulations during the processing of his/her application and thereafter if he/she is granted staff membership or granted AHP status;
- (j) gives his/her authorization and consent for any Hospital Representatives to provide other hospitals, medical association, licensing boards, and other governmental agencies concerned with health care providers performance and the quality and efficiency of patient care with any information pertaining to the applicant, his/her credentials, qualifications, character, professional ethics, competence, health status, and his/her activities and practices at the Hospital, and including, without limitation, all information required to be reported to any governmental authority under the provision of the Health Care Quality Improvement Act of 1986 (42 U.S.C., §11101 et seq.) as amended from time to time (the "Act") in order to allow the Corporation or any Representative to take advantage of any immunity from suit or liability or any defense or other benefit conferred by the Act or any Information required to be furnished to any other governmental authority or agency thereof under any other state, federal, or local law conferring any such immunity from suit or liability or any defense or other benefit on the Corporation or any Representative; and
- (k) authorizes all Representatives to make periodic inquiries as provided by the Act to a designated agency or agencies to obtain any information reported to such agency or agencies on such Practitioner, including, but not limited to, and reported adverse action taken by any Representative against the Practitioner adversely affecting his/her right to exercise clinical privileges or specified services at any hospital or other health care facility.

13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any Representative of the Hospital or Medical Staff or any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with applicable standards of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative authorized to receive same nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This information shall not become part of any particular patient's record.

13.4 IMMUNITY FROM LIABILITY

(a) For Action Taken

No Representative of the Hospital or Medical Staff shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a Representative, if such Representative acts in good faith and without Malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

(b) For Providing Information

No Representative of the Hospital or Medical Staff and no third Party shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative of the Hospital or Medical Staff or to any other health care facility or organization of health care professionals concerning a Practitioner who is or has been an applicant to or member of the Staff or who did or does exercise Clinical Privileges or provides Specified Services at this Hospital, provided that such Representative or third Party acts in good faith and without Malice and provided further that such information is related to the Performance of the duties and functions of the recipient and is reported in a factual manner.

13.5 ACTIVITIES AND INFORMATION COVERED

(a) Activities

The confidentiality and immunity from liability provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

- (1) applications for appointment, Clinical Privileges or Specified Services;
- (2) periodic reappraisals for reappointment, Clinical Privileges, or Specified Services;
- (3) corrective or disciplinary action;
- (4) hearings and appellate reviews;

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- (5) Quality Improvement program activities;
- (6) utilization reviews;
- (7) claims reviews;
- (8) profiles and profile analysis;
- (9) malpractice loss prevention; and
- (10) other Hospital and Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct in the Hospital.

(b) Information

The Information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

13.6 RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of Malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State and the United States. Execution of such releases is not a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information, and immunities from liability are in addition to other protection provided by all applicable law, state as well as federal and not in limitation thereof.

ARTICLE XIV
ADOPTION

These Bylaws have been duly adopted by the Medical Staff, and shall replace any previous Bylaws, and shall become effective when approved by the Board. They shall, after adoption and approval be equally binding on the Corporation and the Medical Staff.

Approved by Medical Staff: Date: 4/18/18	Approved by Board of Trustees: DATE: 4/23/18
	Rev approved by Board of Trustees: Date 8/27/18
	Rev approved by Board of Trustees: Date: 10/22/18
	Rev approved by Board of Trustees: Date 12/10/18
	Rev approved by Board of Trustees: Date 12/9/19
	Rev approved by Board of Trustees: Date 12/14/20
	Rev approved by Board of Trustees: Date 12/10/21
	Rev approved by Board of Trustees: Date 12/7/22
	Rev approved by Board of Trustees: Date 12/9/24

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RULES AND REGULATIONS

I. Meetings

- 1.1 The annual meeting of the Medical Staff shall be held in December of each year. (rev. 3/90)
- 1.2 The President/Chief of Staff may appoint one (1) or more individuals as non-voting members to any one (1) or more of the standing or special committees of the Medical Staff, whose knowledge, expertise, experience, training, independence, objectivity, and/or characteristics are deemed valuable to the functioning of such committees by the President/Chief of Staff, including but not limited to, independent medical experts, attorneys, risk management specialists, insurance consultants, or other experts and consultants who may have valuable experience or expertise. Each person appointed pursuant to this rule shall be a non-voting member of the committee to which he/she is or, if no term is specified, an indefinite term at the pleasure of the President/Chief of Staff. Any such special non-voting person may resign at any time by submitting a written resignation to the President/Chief of Staff effective on the date set out therein or upon acceptance by the President of the Chief of Staff, if no date is specified. Any such non-voting may be removed by the vote of the MEC. Any such non-voting member of a Medical Staff committee appointed under this Rule shall be entitled to all of the benefits, privileges, and immunities from liability as any Medical Staff member of a committee except the right to vote. (8/90)

II. Admission and Discharge of Patients

- 2.1 Except in an Emergency, all patients admitted to the Hospital by a member of the Medical Staff, shall have a provisional diagnosis as soon as possible following admission.
- 2.2 In these Bylaws, and in the Rules and Regulations adopted in connection herewith, unless the context clearly otherwise requires, the following definitions shall apply:
- Attending Physician – The licensed physician who would normally be expedited to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient’s medical care and treatment (8/27/18)
- 2.3 Patients shall be discharged on order of the attending physician and/or an appropriately credentialed APRN or PA, after direct consultation with the attending physician. At the time of discharge, the attending physician and/or the appropriately credentialed APRN or PA, shall see that the record is complete, state his/her final diagnosis, and sign the record. Records completed by appropriately credentialed APRNs or PAs will be signed in accordance with the Medical Staff Bylaws and Hospital Medical Records policies. (rev 6/27/16)
- 2.4 Observation and Admission Guidelines: (rev. 12/14/09 rev. 8/25/14)

A review of the patient’s condition will be performed prior to the patient’s actual occupying of an acute care bed or as close to the time after admission as possible (within one working day of admission) to determine the medical necessity for hospital services and the most appropriate setting for those services. Patients found to be in an inappropriate setting/level of care based on nationally accepted criteria and/or government/payer rulings and regulations, including the CMS’ 2 midnight rule, may be referred for review by a physician advisor and/or “designee” to assess the severity of the patient’s illness or medical condition, treatment planned, and diagnostic and therapeutic services that are being or will be provided to determine if the ordered service is medically necessary and to review the appropriateness of the ordered setting. If necessary, cases may be discussed with the attending physician, the physician advisor, and, if indicated, referred to the Utilization Review Chairman for further review.

- The physician must document to support the level of care that he/she ordered.

- 2.5 Inpatient, Day Surgery and Observation patient records require a discharge summary.
- The Discharge Summary should be completed at the time of discharge; but at maximum, within 30 days following patient’s discharge.
 - Components of the discharge summary include, at a minimum:
 - Outcome of hospitalization
 - The disposition of the patient, and
 - Provisions for follow-up care

Note: For patient stays under 48 hours or of a minor nature as defined by the medical staff, the final progress note may serve as the discharge summary and must contain the same components as outlined above. (rev 12/2013) (rev 8/2026)

- 2.6 For patients who present for readmission that were previously unassigned, the previous treating physician maintains responsibility for the care of that patient if the readmission occurs within 30 days of the prior discharge- *or as determined by the Section (8/25/08) (rev. 12/15/08)*

III. Physicians Orders

- 3.1 All orders for inpatients and outpatients treatment shall be documented. All orders shall be in writing, dated, and timed. Orders shall be considered documented, if identified by the name of the person receiving the order and the name of the practitioner giving the order.
- a. Orders dictated over the telephone and verbal orders are discouraged and should be limited to emergency situations or where the ordering practitioner is physically unable to write the order into the record (e.g. during a procedure). Verbal orders from a physician may be received, written and carried out by an RN, LVN or other authorized licensed professional as deemed appropriate by the Medical Staff (i.e.

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- Registered Pharmacist). (rev. 6/22/15) Orders given by a physician over the telephone and verbal orders from a physician can be taken by specialty licensed, registered and/or certified hospital personnel in the area of their specialty pertaining to their scope of practice. (rev 4/20/22)
- b. Verbal orders shall not be taken for chemotherapeutic agents.
 - c. Verbal orders must be authenticated in accordance with state and federal law. The ordering practitioner, during the next hospital visit, authenticates the order with a signature and the date and time of the signature. *All verbal orders must be authenticated within 96 hours from the time the order was written by the authorized person who received the order.* Guidelines for verbal orders using CPOE, in the Emergency Department, or during clinical downtime are included in the hospital Administrative Policy ADM.07.01.0016 Verbal Orders. (rev 3/2015) (rev 6/22/15)
In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is off duty for the weekend or an extended period of time). In such cases, it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner. (Refer to Facility Restraint Policy regarding verbal order specific to restraints.) (rev. 12/2013) (rev. 6/22/15)
 - d. A signed order for outpatient tests and procedures is required. The *scheduling* of an outpatient test or procedures is not considered an order.
 - e. Refer to hospital policy on advance directives/DNR to determine if verbal orders are permitted. (rev. 8/30/99)
- 3.2 There shall be an automatic stop order on all drugs; however, no drugs shall be stopped until the attending physician has been notified. Notification will occur 48 hours and 24 hours before final scheduled dose. Such drugs are identified as (a) Oxytotic drugs... 2 days; (b) Anti-coagulants (excluding warfarin), Narcotics, Sedatives, Inhalant Respiratory Medications/Treatments... 7 days; (c) all other medications shall be reviewed every 30 days after admission. These orders are authenticated by the practitioner responsible for the patient within 24 hours. (rev. 06/25/92) (rev. 12/17/01) (rev. 6/28/04)
- 3.3 Orders for nutritional consults must be given at least 24 hours prior to discharge. (6/24/97)
- 3.4 The use of signature stamps has been determined to be an unacceptable signature/ordering method of a physician providing/ordering medical services and is therefore prohibited at Hospital. (12/19/91) (rev. 10/27/08)
- 3.5 It is acceptable for the attending physician to sign for physicians covering for them.
- 3.6 It is also acceptable for the physicians in associated groups to sign for each other as long as they are involved for the care of the patient on that hospitalization. (12/21/95)

IV. Patient Care and Treatment

- 4.1 A patient should be seen by a physician daily in an acute care setting. (*refer to 4.2 for Behavioral Health patients rev 8/27/18*). Progress notes will be written daily by an appropriate staff physician. A patient can be discharged if seen by a physician or appropriately credentialed APRN/PA (in accordance with Rule/Reg 2.2) within 24 hours prior to discharge with verbal communication between the discharging provider and nurse upon discharge. Prior to discharge, all providers actively involved in the patient care must be notified. (rev. 12/16/93) (rev. 1/17/03) (rev. 12/17/07) (rev. 6/27/16) (rev. 12/11/17)
- 4.2 A patient at Behavioral Health will be seen and assessed initially by a physician, and will be seen daily thereafter by a physician, or an appropriately credentialed APRN/PA under the supervision of a physician (8/27/18)
- 4.3 All physicians consulted, not their APRN/PA, must see their patient within 24 hours of notification of consult.
- 4.4 In his/her absence, it is the responsibility of the Active Staff member to make provisions for medical, dental or podiatric care direction by another qualified and suitable Active Staff member.
- Practitioner(s) designated as alternate coverage are expected to provide care for those hospital patients in the event of an unexpected absence of the practitioner for whom they provide alternate coverage.
- In the event the attending physician or his designee cannot be reached, the Section Chairman has the authority to appoint a physician to continue the care of a patient(s). The ER Call Specialty Coverage Listing can be utilized in these cases. ((12/21/95 rev. 6/25/07)
- 4.5 All members of the Medical Staff are required to provide and maintain full contact information to the Medical Staff Office. (to include: office phone, answering service, cell phone, pager number. (6/25/07)
- 4.6 The Infection Prevention Department under the Infection Control Committee has the authority to institute any surveillance, prevention and control measures or studies deemed necessary and to recommend corrective actions(s) when there is reason to believe a condition(s) exists which places patients, visitors, staff, or the environment at risk for infection. (rev. 7/31/00 rev 12/10/18)
- 4.7 Physicians are required to return calls within a timely manner. This has been determined to be within 15 minutes of a call placed for routine calls. A 15 minute non-response to a 2nd call – will be considered non-compliance and will be address through peer review. (12/14/09)
- 4.8 The Hospital's pathologists are requested to provide professional written interpretations on clinical laboratory reports when, according to the

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medical judgment of the pathologist, such interpretations are indicated. (3/26/92)

- 4.9 Physician accountable for:
- * accessing and ordering testing and treatment for all patients (inpatient, outpatient, emergency patients)
 - * supplying all prior and new diagnoses to the hospital prior to testing
 - * providing this information in a timely manner for more efficient testing and reporting and charging. (6/24/97)
- 4.10 No treatment shall be performed until written consent has been obtained from the patient or his/her legal representative, except in dire emergencies. (rev. 6/29/98)

V. Consultations

- 5.1 In cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital staff, through its Section Chairman and the Executive Committee to see that members of the Staff do not fail in the matter to call consultants as needed. The consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made a part of the record. When operative procedures are involved, the consultation, except in emergency, shall be recorded prior to the operation.
- 5.2 Privileges for specialty procedures and management inherent to the care of critical care patients are determined through the Medical Staff credentialing process. Qualified consultants must be obtained for specialty procedures or management which required delineated privileges. "Qualified" is defined by the Medical Staff Section granting this privilege and is based on training and experience. A list of physicians with privileges in specialty procedures and management who have been approved through the Medical Staff credentialing process is maintained in ICU, CCU, and Pedi-ICU, Cardiac Cath Lab, Radiology, and Surgery. (rev. 6/91)
- 5.3 InHouse Consults (rev 4/23/18)
- If a physician is on call for his/her specialty for ER, that physician is also required to see in-house consults for that specialty (rev 4/23/18)
 - In an emergency consult, it is the responsibility of the physician requesting the consult, to make personal contact with the physician he/she is consulting. (2/28/05)
 - The physician on call for that specialty will:
 - be called at the time the order is entered into CPOE or written;
 - Accept the patient; unless the physician is no longer on call.
 - Contact the next physician on call if a consult is called to him/her when he/she is no longer on call.
 - Accept the consult and evaluate the patient; call the patient's established specialist with report. (4/23/18)

VI. Anesthesia

- 6.1 In compliance with the directive from the Texas Department of Health Resources Hospital Licensing Division, a policy of not using or storing flammable anesthesia will be adhered to in the surgical suite.
- 6.2 The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:
- * Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
 - * Cardiovascular function, including pulse rate and blood pressure;
 - * Mental status;
 - * Temperature;
 - * Pain;
 - * Nausea and vomiting;
 - * Post-operative hydration.
 - * Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

VII. Surgical Practice

- 7.1 Surgeons must be in the operating room and ready to commence an operation at the time scheduled and a procedure that does not begin until fifteen minutes after the time scheduled, will be documented as a late start and may incur additional penalties as determined by the Section. (rev 10/19/22)
- 7.2 Only authorized hospital personnel and members of the medical and dental profession in proper attire will be permitted in the surgical suite of the hospital.
- 7.3 It is permissible for surgeons to discard the following specimens, if no examination by Pathology is desired:
- a. Cataracts
 - b. Indwelling catheters and stent

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- c. Orthopedic, dental, and plastic surgical hardware
- d. Teeth
- e. Bunions
- f. Hammertoe deformities
- g. Bone/cartilage from nasal septoplasties
- h. Loose bodies from joints
- i. Meniscectomy and meniscus shavings
- j. Skin from blepharoplasty and facelifts
- k. Liposuctions
- l. Vaginal mucosa form A/P repairs and enteroceles
- m. Pediatric (<16 y.o.) foreskins (rev. 12/16/93) (rev. 9/30/96)

- 7.4 Before operative and other procedures or the administration of moderate or deep sedation or anesthesia, the site, procedure and patient are identified. The patient is reevaluated immediately before moderate or deep sedation and before anesthesia induction. The anesthesiologist or other qualified individual shall record a pre-operative note and a post anesthetic follow up on the chart. No patient will be sent to the operating room suite, if the site is not marked. (5/23/05)

VIII. Medical Records

- 8.1 Only authorized individuals are permitted to make entries in the medical record. Authorized individuals include those directly involved in the patient's care/treatment. All entries in the medical record should be signed, dated and timed. (3/17/08) (rev. 12/14/09)
- 8.2 The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, chief complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, x-ray and others, provisional diagnosis, condition on discharge and progress notes. No medical record shall be filed until it is complete except on order of the Medical Records Committee.
- 8.3 Emergency Room (ER) physicians are granted the privilege to perform a history and physical (H&P). For ER patients requiring surgery, the assessment completed by the ER physician may be used as the H & P to proceed to surgery, consistent with the minimum content requirements as defined by the medical staff, with an update by the surgeon/proceduralist stating they have reviewed the ER record.
- 8.4 If a history and physical examination has not been recorded or dictated prior to surgery/special procedure *involving anesthesia*, the operation/special procedure shall not proceed unless the attending surgeon states, in writing, that such a delay would constitute a hazard to the patient. (rev. 6/89) (rev. 12/14/09) (rev. 1/23/17)
- 8.5 Operative reports and invasive procedure reports are dictated or written immediately following any surgical or high-risk invasive procedure and entered into the patient's medical record and signed by the surgeon/practitioner. Any Staff member having undocumented op reports greater than 30 days post procedure will be required to pay a fine of \$200 with an additional fine of \$500 to be imposed for a subsequent offense occurring within a rolling 12 month period. (rev. 4/28/25)

The post-operative / invasive procedure report must include at least:

- Name and hospital identification number of the patient;
- Date and times of the surgery / procedure;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical / invasive tasks (even when performing those tasks under supervision);
- Pre-operative diagnosis and post-operative diagnosis;
- Name of the specific procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Prosthetic devices, grafts, tissues, transplants or devices implanted, if any. (rev. 7/21/21)

All tissues removed at operation (with the elected exceptions as listed in 7.3) shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis. A signed report of his/her findings shall be made a part of the patient's record.

SR.3 In the event that an operative report cannot be dictated and placed on the patient's chart before transfer to the next level of care, an immediate postoperative/post procedure note is required to be documented. The note shall include identification or description of:

- SR.3a The surgeon and assistants
- SR.3b Pre-operative and post-operative diagnosis;
- SR.3c Procedures performed;
- SR.3d Specimens removed;
- SR.3e Estimated blood loss (blood administered as needed – may indicate where in chart for detail);
- SR.3f Complications (if any encountered);

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- SR.3g Type of anesthesia administered; and
SR.3h Grafts or implants (may indicate where in chart for detail). (rev. 6/22/15)

- 8.6 All records are the property of the Hospital. Medical Staff Rules and Regulations prohibit the removal of medical records from the hospital's jurisdiction and safe-keeping except as a result of court order, subpoena or statute. In case of readmission of patient, all previous records shall be made available for use of the attending physician. This shall apply whether he or she be attended by the same or a different physician.
- 8.7 Any Staff member failing to complete patient records (inpatient/outpatient) within thirty (30) days following the discharge of the patient from the hospital will automatically have his/her clinical privileges (except with respect to his/her patients already in the hospital, inpatient and outpatient cases already posted and scheduled at the time of the suspension, outpatient diagnostics, and Oncology treatments for establishes patients i.e. radiation, chemotherapy, and infusions), his/her right to admit patients and to consult with respect to the patients, his/her right to perform surgery or special procedures or to care for his/her partners' patients, and his/her voting and office holding prerogative suspended and continue to be suspended until all available medical records are completed. Exception to this may be made by the CEO or designee. Any exception made during the course of suspension does not reset the timeline of the suspension and the suspension remains intact other than for the specific exception granted. At the regularly scheduled monthly meeting of the Medical Executive Committee, members shall receive a listing of physicians who remain on the suspension list for their review and determination of appropriate action to be taken. The Physician having lost privileges specifically may not post patients for admission or surgery/special procedure in the name of a second physician. A second physician permitting use of his/her name to circumvent this rule shall lose the same privileges for the same period as the suspended physician. Suspended Staff members shall continue to take Emergency Room call but can only admit patients seen as emergencies on the day the physician is officially on emergency room call. Actions by the physician to circumvent this rule (i.e. sending patient for procedure without posting) will result in referral to the MEC. (rev. 12/16/93) (rev. 7/31/00) (rev. 5/23/16)

All outpatient clinic records must be completed (dictations/signatures) within thirty (30) days of the patient encounter. (5/07)

Any suspended Staff member who fails to complete all available records by the next scheduled Board of Trustees meeting, shall be subject to further action up and including termination of his/her medical staff membership privileges. If termination occurs, it is considered a voluntarily resignation from this staff and is not reportable and said physician will not be entitled to a fair hearing. A request for reinstatement of membership/privileges will require a fee of \$500.00 and completion of all medical records. Reinstatement can then be approved by the Director of Medical Records and the CEO (or his designee) pending final approval by the Board of Trustees at their next scheduled meeting. If reinstatement has not occurred by the date of the next Board meeting, the physician would then be required to reapply for medical staff membership and privileges. (rev. 12/12/05) (rev 5/23/16)

- 8.8 Suspension will occur once a month. The suspension and physician notification process to be followed by the Medial Record Department is illustrated below:
- ▶ #1 – Notice of Incomplete Records will be sent the 1st Wednesday of each month.
 - ▶ #2 - Notice of Delinquent Records will be sent the 2nd Wednesday of each month.
 - ▶ #3 – Notice of Automatic Suspension will be sent the 3rd Wednesday of each month.
 - ▶ #4 – Notice of referral to MEC will be sent the 4th Wednesday of the month if the physician remains on suspension at that time. (12/2020)
- 8.9 Any Staff member who has been reported to MEC a minimum of three (3) times in a rolling 12 month period for delinquent records, will be required to pay a fine of \$500.00.
- The staff member will be alerted on these notices regarding the # of times notified within the 12 month period
 - The staff member – following the 3rd time – will be sent a communication from MEC notifying them that the \$500.00 fine is due – and payable within one week following Board notification. (3/26/07) (rev. 1/22/08) (rev. 12/2020)

IX. Medical Staff

- 9.1 A Medical Staff Account shall exist and a final financial statement shall be given to the Medical Executive Committee on an annual basis. (rev. 3/90) (rev. 3/04)
- 9.2 The Surgery Section shall advise the MEC and the board on all matters pertaining to laser safety, shall review policies and procedures for laser use in the Hospital, and shall review Physicians who currently hold laser privileges. (12/16/93)
- 9.3 Any staff member failing to renew licenses (Texas State Board, DEA) and/or liability coverage upon expiration of the prior proof on file will automatically, after written warning of delinquency, have his/her clinical privileges, his/her right to admit patients and to consult with respect to the patients, his/her right to perform surgery or special procedures or to care for his/her partner's patients, and his/her voting and office holding prerogative suspended. Allied Health Professionals who provide Specified Services in the Hospital and assist members of the Medical Staff in the care and treatment of Hospital patients are also subject to this ruling. The suspension will continue until he/she provides the necessary proof or until determination of further action is made by the Medical Executive Committee at their next scheduled meeting regarding medical staff membership of the suspended member. The Physician/Dentist/Podiatrist having lost privileges specifically may not post patients for admission or surgery/special procedure in the name of a second physician. A second physician permitting use of his/her name to circumvent this rule shall lose the same privileges for the same period as the suspended physician. Transfer of care of patients already in the hospital is the responsibility of the physician/dentist/podiatrist whose privileges are being suspended until he/she provides the necessary proof. It is the responsibility of the

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suspended member to obtain replacement coverage for any ER Call dates for which he/she has been assigned until such time that he/she provides the necessary proof. (12/15/94) (rev. 6/22/15)

X. Pronouncement of Death

- 10.1 The cause of death is to be clearly documented in the discharge summary. (12/19/91)
- 10.2 When a person is found to have no spontaneous respiratory or circulatory function, a physician, physician's assistant (PA) or Advanced Practice Professional (APN), who is duly credentialed by the Medical Staff of BHSET or Registered Nurse who is employed by BHSET acting under the physician's order, may declare death. A death note is to be entered in the progress notes of the patient's chart, stating time of death, notification of family, and name of physician, by the physician's assistant, APN or Registered Nurse declaring death. In the event the death is designated as a "coroner's case" the Nursing Supervisor must notify the coroner. The Nursing Supervisor may pronounce the patient once it has been determined by the coroner that no further action or investigation by the coroner is required.

XI. Autopsies

- 11.1 Every member of the Medical Staff is expected to be actively interested in securing autopsies. The Medical Staff should attempt to secure autopsies in all cases of unusual deaths and of medico-legal and educational interest. (Defined below in Section 11.2) (rev. 6/24/93) (rev. 5/23/05) (rev 12/13/10)
- 11.2 The current guidelines for cases of hospital death in which a request for autopsy should be considered are:
- Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
 - Death in which the cause of death is not known with certainty on clinical grounds.
 - Hospital death occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
 - Sudden, unexpected and unexplained hospital deaths which are apparently natural and not subject to forensic medical examiner's jurisdiction.
 - Deaths in which the patient sustained or apparently sustained an injury while hospitalized (e.g. fell out of bed). (rev. 9/30/93)

Autopsies are not performed at Baptist Hospitals of Southeast Texas or by Pathologist at the hospital.

Autopsies requested by medical staff or families must be performed by a private Pathologist secured by the family or physician. After the Attending Physician or physician's representative discusses the recommendation of an autopsy with the family, the hospital will provide information to assist in locating a private Pathologist. The physician shall give an order for an autopsy. (rev. 12/13/10)

XII. Emergencies

- 12.1. The Executive Committee of the Medical Staff shall be responsible for the organization and function of the Emergency Service. Members of the Active Staff shall be required to take the responsibility of call in the Emergency Service. The Executive Committee shall have the authority to determine who should be excused from taking calls in this service. Staff members who want to be excused from taking calls for reason of health, residence, etc. may apply in writing to the Executive Committee stating their reasons. Each Section of the Staff will have the authority to determine age limits for Emergency Room Service, with each doctor on the On Call lists being responsible for his/her own replacement. Emergency Service obligation shall continue for any member suspended from the staff unless he/she submits his/her resignation from the Staff to the Chief Executive Officer of the Hospital in writing or the Executive Committee deems it in the best interest of patients and the hospital that he/she not take Emergency Room Call. Any Staff physician failing to fulfill his emergency service obligation shall be subjected to temporary loss of Medical Staff privileges. (rev. 3/90)
- Every section must maintain an "on call" list in the Emergency Room.
 - No physician may be required to be on-call more than 10 days a month. No physician will be required to take call more than 10 times a month.
 - Consultation for an on-call physician remains a physician to physician responsibility. The physician requesting an emergency consultation of an on-call physician must communicate directly with the on-call physician and identify the emergency condition and specify that an emergency condition exists.
 - On-call physicians are required to respond in a timely manner to emergency conditions for hospitalized patients as well as emergency department patients.
 - On-call physicians may remain responsible for patients with emergency medical conditions that are stable for discharge from the hospital, but require follow-up stabilizing care of the emergency medical condition.(rev. 2/25/02)
 - There is a two month time period before a new member of the medical staff is inserted in the ER Call rotation. (4/28/08)
 - Simultaneous Cardiac Alerts – Cardiologists have established a community ER call schedule. In the instance simultaneous cardiac alerts occur, and the physician who is on ER call is occupied with a cardiac alert, another physician from the alternate group will manage the additional cardiac alert. (5/20/24)

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- 12.2. Hospital and Medical Staff shall comply with Hospital Policies and Procedures regarding triage, intake, and medical screening examination by qualified personnel, and regarding the duty to stabilize unstable patients in the Emergency Room prior to any patient transfer. Although Allied Health Professionals may be designated by physicians on the Medical Staff as qualified medical personnel to conduct medical screening examinations of Emergency Room patients (including pregnant patients in labor), final authorization for discharge or transfer from Hospital Emergency Room shall be made by a physician who is a member of the Medical Staff. No patient shall be transferred until the receiving facility has accepted transfer, the patient is determined by a physician to be in stable medical condition, and all Hospital Policies and Procedures addressing patient transfers are followed. (5/23/05)
- 12.3. Members of the staff should be aware that for any diagnostic or surgical procedures or skills that they provide during the regular course of their practice, they must be available for their emergency room call pertaining to the same procedures.
- 12.4. If a member of the staff does not wish to take call for a specific area normally considered part of their specialty, then they must exclude that from their regular privileges. (3/24/94)
- 12.5. ER Call requires the on call physician to assist with triage, stabilization and disposition of the patient, when requested. (6/28/10)

XIII. Continuing Medical Education (CME)

All medical staff with delineated clinical privileges shall participate in continuing education which is relevant to the clinical privileges as granted with the minimum number of hours required established at forty-eight (48) hours over a two year period. This continuing professional education shall be documented and considered at the time of reappointment to the medical staff and/or renewal or revision of individual clinical privileges. (12/16/93) (rev. 3/23/98)

XIV. Telemedicine

Telemedicine is the use of any electronic medium, except telephone, by a licensed independent physician member of the Staff to provide interpretive services for the diagnosis or treatment of a patient at Baptist Beaumont Hospital ("Hospital").

Physicians providing telemedicine services must be members of the Hospital Medical Staff; and shall be credentialed and privileged for relevant services in accordance with the requirement of the Credentialing Manual. Credentialing information from the site where the Practitioner providing the services is located ("Originating Site") may be used by the Hospital to establish privileges if the Originating Site is a Regulatory accredited organization.

Practitioners providing telemedicine services who are physically located outside the State of Texas, likewise shall be credentialed and privileged in accordance with the requirement of the Credentialing Manual and shall be required to present a current Special Purpose License for Practice of Medicine Across State Lines ("SPL") as required by the laws of the State of Texas.

All telemedicine services shall be provided pursuant to a contract in accordance with such terms and conditions as the Hospital from time to time may require.

Telemedicine consultations shall be condensed to a permanent form, to include dictated or written text, or audio/video. (12/15/03)